

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02501

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

DHMH 17 Rev 1/2001

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LUCY LONG BOYD</b>   |   | 2. Date of Death<br>Month Day Year<br><b>JAN 14, 2008</b>   |  | 3. Time of Death<br><b>10:07A<sup>M</sup></b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>21311 Woodfield Road</b>   |   | 4b. City, Town, or Location of Death<br><b>Gaithersburg</b>   |  | 4c. County of Death<br><b>MONTGOMERY</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>223-30-1417</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>May 30, 1930</b>   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |
|  | Usual Residence of Decedent   |   |   |  |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   | 10b. County<br><b>Montgomery</b>  | 10c. City, Town or Location<br><b>Gaithersburg</b>  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|  | 10e. Street and Number<br><b>21311 Woodfield Road</b>   |   | 10f. Zip Code<br><b>20882</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>           |  |   |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Microbiologist</b>  |   | 16b. Kind of Business/Industry<br><b>FLOLABS</b>  |  |   |
| To Be Completed by Physician/Medical Examiner  | 17. Father's Name (First, Middle, Last)<br><b>Ernest Long</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Fannie Lambert</b>  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Felicia Elder (Daughter)</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20904 12518 Stratford Garden Dr, Silver Spring, MD</b> |  |   |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Brooke Grove Cem</b>   |  | 20c. Location - City or Town, State<br><b>1/19/08 Laytonsville, MD</b>  |
|  | 21. Signature of Funeral Service Licensee<br><i>George R. Sauer</i>   |   | 22. Name and Address of Facility<br><b>SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850</b>   |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia</b><br><b>Diabetes</b>   |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |   |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred   |   |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |   |
| 29b. Signature and title of certifier<br><i>Patricia Tomsko May, MD</i>  |   | 29c. License number<br><b>D51916</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>Jan. 14, 2008</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Patricia Tomsko May, MD, 11119 Rockville Pike, G-100, Rockville, MD 20852</b>   |   |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JAN 16 2008</b>  |   | 32. Registrar's Signature<br><i>Benjamin K. Spent</i>   |   |  |   |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02502

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Jean Carty

2. Date of Death

January 23 2008

3. Time of Death

1305 M

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

216-44-1231

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

8. Date of Birth

12/5/1942

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

24 Lapidum Road

10f. Zip Code

21078

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

In Home

17. Father's Name (First, Middle, Last)

Willie Whittaker

18. Mother's Name (First, Middle, Maiden Surname)

Shirley UNK

19a. Informant's Name/Relationship (Type, Print)

Franklin Carty (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

24 Lapidum Rd. Havre de Grace, MD 21078

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harford Memorial Gdns.

Date

1/26/08

20c. Location - City or Town, State

Aberdeen, MD

21. Signature of Funeral Home Licensee

BT Francis

22. Name and Address of Facility

Tarring-Cargo Funeral Home, P.A.  
Aberdeen, Maryland 21001-3399

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Breast cancer  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ COAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Dr. Charles

29c. License number

D 58303

29d. Date signed (Month, Day, Year)

January 24 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arion J. Charles MD 6701 N. Charles St Towson MD 21204

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 31 2008

32. Registrar's Signature

Arion J. Charles

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21204

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02503

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Doris Stovold Corddry

2. Date of Death

Jan. 09, 2008

3. Time of Death

12:25 P M

4a. Facility Name (If not institution, give street and number)

La Casa, LLC Assisted Living

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

024-14-5456

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

8. Date of Birth (Month, Day, Year)

May 13, 1923

9. Birthplace (State or Foreign Country)

Maine

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

946 Schooner Circle

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year of Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Henry William Stovold

18. Mother's Name (First, Middle, Maiden Surname)

Ida Bowton

19a. Informant's Name/Relationship (Type, Print)

William H. Corddry/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

946 Schooner Circle Annapolis, Maryland 21401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date Jan. 11, 2008

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Thomas E. Allen

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Gov. Ritchie Hwy, Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Malnutrition

Due to (or as a consequence of):

c. Dementia

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

one week

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Assisted Living

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lucinda Mundorf MD

29c. License number

D0062705

29d. Date signed (Month, Day, Year)

01-10-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lucinda Mundorf, MD 116 Defense Hwy. Suite 400 Annapolis 21401

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature

Heaven &amp; Spence

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02504

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth P. Crilly

2. Date of Death

1/11/2008

Year

3. Time of Death

1040 a M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

220-74-2924

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
9/30/1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Shady Side

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1123 Steamboat Rd.

10f. Zip Code

20764

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John S.W. Parks

18. Mother's Name (First, Middle, Maiden Surname)

Lina Lee Whittington

19a. Informant's Name/Relationship (Type, Print)

Ginger Griffith Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1123 Steamboat Rd. Shady Side, MD 20764

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. James Cemetery

Date

1/15/2008

20c. Location - City or Town, State

Lothian, MD

21. Signature of Funeral Service

J. J. [Signature]

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Ave. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Urinary Tract Infection

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D39037

29d. Date signed (Month, Day, Year)

1/14/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Mitchell, M.D. 2001 Medical Pkwy. Annapolis, MD 21401

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02505

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

KEVIN P. CURLEY

2. Date of Death

January 12, 2008

3. Time of Death

5:31 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

NONE

5. Social Security Number

196-46-7388

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50

8. Date of Birth

APRIL 23, 1957

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

PENNSYLVANIA

10b. County

DELAWARE

10c. City, Town or Location

HAVERTOWN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

148 WOODBINE ROAD

10f. Zip Code

19083

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

—

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FORKLIFT OPERATOR

16b. Kind of Business/Industry

LUMBER

17. Father's Name (First, Middle, Last)

LOUIS J. CURLEY

18. Mother's Name (First, Middle, Maiden Surname)

SARAH M. DOWNEY

19a. Informant's Name/Relationship (Type, Print)

LOUIS J. CURLEY/BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

148 WOODBINE ROAD, HAVERTOWN, PENNSYLVANIA 19083

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATION CENTER

Date

JANUARY 14, 2008

20c. Location - City or Town, State

STEVENSVILLE, MARYLAND

21. Signature of Funeral Service Licensee

Will Edwards M00672

22. Name and Address of Facility FELLOWS, HELFENBETH &amp; NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BEECHGATE ROAD, ANNAPOLIS, MARYLAND 21401

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Arrhythmia  
Due to (or as a consequence of):  
b. Hypoglycemia  
Due to (or as a consequence of):  
c. Clinical Sepsis  
Due to (or as a consequence of):  
d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sudheer Kantharajapur MD

29c. License number

89579

29d. Date signed (Month, Day, Year)

January 12, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sudheer Kantharajapur, M.D. c/o Maryland General Hospital

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature

Kevin B. Smith

State  
Registrar

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02507

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Melvin Joseph Caldwell

2. Date of Death

Month Day Year  
1 12 2008

3. Time of Death

1223 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Peninsula Regional Medical Center Salisbury, MD

4b. City, Town, or Location of Death

Wicomico

5. Social Security Number

217-16-4890

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

84

8. Date of Birth

If Under 1 Year If Under 24 Hrs.  
Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 22, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5437 Loch Ness Terrace

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: 1943-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Attorney

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

William Thomas Caldwell

18. Mother's Name (First, Middle, Maiden Surname)

Henrietta Thiess

19a. Informant's Name/Relationship (Type, Print)

Melvin J. Caldwell, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5437 Loch Ness Terrace, Salisbury, MD 21801

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veterans Cemetery

Date

1/16/2008

20c. Location - City or Town, State

Beulah, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Zeller Funeral Home, P. O. Box 3171  
1212 Old Ocean City Road, Salisbury, MD 21802

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Complication of hip fracture

b. Due to (or as a consequence of):

pneumonia

c. Due to (or as a consequence of):

Coronary artery disease

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death  
☐ Pregnant at time of death  
☐ Unknown

3. Ectopic pregnancy

5. Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation  
☒ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

12/27/07

28b. Time of Injury

1800 M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

Grand Level Fall

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Nursing home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

200 Civic Ave

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

C. Snyder ME

D31546/450497

29d. Date signed (Month, Day, Year)

1/14/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chris Snyder + Ignatius Dinardo

100 E. Carroll St. Salisbury MD

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02508

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eleanor V. Cannatella

2. Date of Death

January 10, 2008

3. Time of Death

7:32P. M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

5. Social Security Number

578-28-1340

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 23, 1922

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11312 Cherry Hill Road, #102

10f. Zip Code

20705

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

John Thorpe

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Ortt

19a. Informant's Name/Relationship (Type, Print)

Richard G. Cannatella -son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11312 Cherry Hill Rd., #102 Beltsville, Maryland 20705

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 1/13/2008

Date

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, PA

4400 Powder Mill Road Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Heart Failure

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Reshma Modi

29c. License number

307614298

29d. Date signed (Month, Day, Year)

1/11/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Reshma Modi, D.O. 7474 Greenway Center Drive Greenbelt, Maryland 20770

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

Reshma Modi

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02509

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edith Maureen Donohoe

2. Date of Death

Month Day Year  
January 13, 2008

3. Time of Death

9:30 A M

4a. Facility Name (If not institution, give street and number)

217 Linden Avenue

4b. City, Town, or Location of Death

Edgewater

4c. County of Death

Anne Arundel

5. Social Security Number

579-34-8622

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
3/5/1930

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Edgewater

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

217 Linden Avenue

10f. Zip Code

21037

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Martin Conley

18. Mother's Name (First, Middle, Maiden Surname)

Edith Cecelia (unknown)

19a. Informant's Name/Relationship (Type, Print)

Karen T. Donohoe/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

402 Lakeview Avenue, Edgewater, MD 21037

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Kalas Crematory

Date

1/15/08

20c. Location - City or Town, State

Edgewater, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home  
2973 Solomons Island Rd. Edgewater, MD 2103723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CAD

Due to (or as a consequence of):

b. A F I B

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

4RS

4RS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

P30708

29d. Date signed (Month, Day, Year)

01-14-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J Socken MD, 2003 New Key, Annapolis, MD 21401

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02510

1- For  
State  
Registrar

|  |   |   |   |  |   |  |  |   |  |  |   |  |
|--|---|---|---|--|---|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Francis John Doyle Jr.</b>   |   |   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>Jan 14 2008</b>   |   | 3. Time of Death<br><b>8:54 A M</b>  |  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b>  |   |   |  |   |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>   |   | 4c. County of Death<br><b>Anne Arundel</b>   |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>177-36-6329</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan 25, 1946</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                                |  |   |  |
|  | Usual Residence of Decedent   |   |   |  |   |  |  |   |  |  |   |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Arnold</b>  |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |  |
|  | 10e. Street and Number<br><b>545 Bay Green Drive</b>  |   |   |  | 10f. Zip Code<br><b>21012</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Vietnam</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Salesman</b>  |  |   |  | 16b. Kind of Business/Industry<br><b>US Steel</b>  |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner                        | 17. Father's Name (First, Middle, Last)<br><b>Francis John Doyle Sr.</b>  |   |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth Weidman</b>   |   |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary E. Doyle/ Wife</b>  |   |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>545 Bay Green Drive Arnold, Maryland 21012</b> |   |  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD Veterans Cemetery</b>   |  | Date<br><b>Jan 17, 2008</b>  |   | 20c. Location - City or Town, State<br><b>Crownsville, MD</b>                                  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>James E. Barranco</i>   |   |   |  | 22. Name and Address of Facility<br><b>Barranco &amp; Sons, P.A. Severna Park Funeral Home<br/>495 Gov. Ritchie Hwy, Severna Park, MD 21146</b>   |  |  |   |  |  |   |  |
| Physician<br>/Medical<br>Examiner                                    | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Lung Cancer</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |   |   |  |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>1 month</b>  |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |   |   |  |   |  |  |   |  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |
|  | 23d. Date of delivery<br>Month Day Year   |   |   |  |   |  |  |   |  |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |  |  |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  |   |  |
|  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |   |  |  |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                  |   |   |  |   |  |  |   |  |  |   |  |
| State Registrar  | 29b. Signature and title of certifier<br><i>James E. Barranco, MD</i>   |   |   |  | 29c. License number<br><b>DS2830</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>January 14, 2008</b>   |   |  |  |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jeanine Werner MD 900 Bestgate Road #300, Annapolis, MD 21401</b>  |   |   |  |   |  |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 15 2008</b>              |   | 32. Registrar's Signature<br><i>Kevin H. Spivey</i> |   |  |   |  |  |   |  |  |   |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02511

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Salvatore

J.

Donato

2. Date of Death

January 4, 2008

Day

Year

3. Time of Death

11:00 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

5801 Spell Road

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

5. Social Security Number

578-34-3469

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Feb. 23, 1930

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5801 Spell Road

10f. Zip Code

20735

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: War Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

2 College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Division Chief

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

John B. Donato

18. Mother's Name (First, Middle, Maiden Surname)

Marguerite DiMisa

19a. Informant's Name/Relationship (Type, Print)

Kathryn R. Donato/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5801 Spell Rd. Clinton, Md. 20735

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery 1/8/2008

Date

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home PA  
6160 Oxon Hill Road Oxon Hill, Maryland 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0064801

29d. Date signed (Month, Day, Year)

1/7/8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bhavin Patel, M.D. 7501 Surratts Rd. #307 Clinton, Md. 20735

31. Date filed (Month, Day, Year)

JAN 08 2008

32. Registrar's Signature

Bhavin Patel

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-343-2000.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02512

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JANICE

DOPMAN

2. Date of Death

Month

Day

13 Year

2008

3. Time of Death

11:05 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

10300 GAS HOUSE PIKE

4b. City, Town, or Location of Death

NEW MARKET

4c. County of Death

FREDERICK

5. Social Security Number

131-24-4502

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

MAY 29, 1930

9. Birthplace (State or Foreign Country)

N.Y.

Usual Residence of Decedent

10a. State

MD.

10b. County

FREDERICK

10c. City, Town or Location

NEW MARKET

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10300 GAS HOUSE PIKE

10f. Zip Code

21774

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOME MAKE

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

WILLIAM

HEIN

18. Mother's Name (First, Middle, Maiden Surname)

ALICE

BERKEN

19a. Informant's Name/Relationship (Type, Print)

JANE CLARK

(DAU)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10300 GAS HOUSE PIKE NEW MARKET MD. 21774

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

1-17-08

20c. Location - City or Town, State

CALVERTON NY

21. Signature of Funeral Service Licensee

Gary L. Rollins

22. Name and Address of Facility

GARY L. ROLLINS FUNERAL HOME  
110 WEST SOUTH ST FREDERICK MD 2170123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Hepatic Failure

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Advanced Breast Cancer

Due to (or as a consequence of):

9 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas Johnson

29c. License number

D 41866

29d. Date signed (Month, Day, Year)

January 14, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

46 B

Thomas Johnson Drive

Kuran Haddock, MD

Frederick MD 21702

31. Date filed (Month, Day, Year)

JAN 18 2008

32. Registrar's Signature

Bryan H. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
 Amend Items 10e, 18 per fh, g903.05/26/2010dhh  
 Certificate of Death

2008 02513

1- For State Registrar

Reg. No.

Physician / Medical Examiner

Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>John Dissek</b>  |  | 2. Date of Death<br>Month <b>01</b> Day <b>21</b> Year <b>2008</b>  |  | 3. Time of Death<br><b>8:24 AM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Harford Memorial Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Havre de Grace</b>   |  | 4c. County of Death<br><b>Harford</b>   |  |
| 5. Social Security Number<br><b>060-22-2496</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br><b>2/1/1928</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>   |  |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Belcamp</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>1304 Cranesbill Ct. Greensbill Ct. Unit 202</b>  |  | 10f. Zip Code<br><b>21017</b>   |  |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates <b>Korea Vietnam</b> |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>4</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Military</b>  |  | 16b. Kind of Business/Industry<br><b>U.S. Government</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Dissek, Sr.</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Prizelant Pryshliwsky</b>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Michael J. Dissek (Son)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>123 Bluebill Ct. Havre de Grace, MD 21078</b>   |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>R. A. Ferris &amp; Co.</b>   |  | 20c. Location - City or Town, State<br><b>West Chester, PA</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>Kersten Anger Ungelesbee</b>  |  | 22. Name and Address of Facility<br><b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>COPD</b><br>Due to (or as a consequence of):<br><b>C. Diff. Colitis</b><br>Due to (or as a consequence of):<br><b>4 weeks</b>          |  | Approximate Interval Between Onset and Death<br><b>710 years</b>  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)<br><input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                    |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)         |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Angela Poppe Ries, MD</b>   |  | 29c. License number<br><b>D0065827</b>  |  |
| 29d. Date signed (Month, Day, Year)<br><b>1/21/08</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Angela Poppe Ries, MD Harford Memorial Hospital</b>  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 22 2008</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |   |  |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- amend #1&17 Per Phy & FH 6876 2/04/08 JH  
 State of Maryland / Department of Health and Mental Hygiene  
 Certificate of Death  
 Reg. No. 2008 02514

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Esperanza Estela Sigaran de Vargas</b>  |  | 2. Date of Death<br>Month <b>Jan</b> Day <b>12</b> Year <b>2008</b>   |  | 3. Time of Death<br><b>12:35 PM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>University of Maryland Medical Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>N/A</b>  |  |
| 5. Social Security Number<br><b>212-57-4688</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>Feb. 4, 1942</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>El Salvador</b>  |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Taneytown</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>409 Clover Court</b>   |  | 10f. Zip Code<br><b>21787</b>  |  |
| 10g. Citizen of What Country?<br><b>El Salvador</b>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify <b>Salvadoran</b>  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>4</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>   |  | 16b. Kind of Business/Industry<br><b>Education</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Abraham Sigaran</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Angela Flores de Sigaran</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Salvador Vargas/Husband</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>409 Clover Court, Taneytown, MD 21787</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cementerio General de Usulután</b>   |  | 20c. Location - City or Town, State<br><b>Usulután, El Salvador</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>James S. Deady</b>   |  | 21. Name and Address of Facility<br><b>Francis J. Collins Funeral Home Inc.<br/>500 University Blvd., W. Silver Spring, MD 20901</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pulmonary Hypertension</b><br>Due to (or as a consequence of):<br>a. _____<br>b. _____<br>c. _____<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown<br><input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)    |  | 23d. Date of delivery<br>Month _____ Day _____ Year _____  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus</b><br><b>Hypothyroidism</b>  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)<br><b>M</b>   |  | 28b. Time of Injury<br><b>1</b> Yes <input type="checkbox"/> No  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Philip C. Dittmar MD</b>   |  | 29c. License number<br><b>P19694</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>Jan 12, 2008</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Philip C. Dittmar MD 22 South Greene Street, Baltimore, MD 21201</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 15 2008</b>  |  | Registrar's Signature<br><b>Kevin H. Spence</b>   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02515

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Antonius H. Dassen

2. Date of Death

January 10, 2008

3. Time of Death

6:05 A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

11610 Game Preserve Road

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

577-48-4116

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 17, 1927

9. Birthplace (State or Foreign Country)

Netherlands

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11610 Game Preserve Road

10f. Zip Code

20878

10g. Citizen of What Country?

Netherlands

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Bricklaying Contractor

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Laurentius Dassen

18. Mother's Name (First, Middle, Maiden Surname)

Marie Janssen

19a. Informant's Name/Relationship (Type, Print)

Jane A. Dassen / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11610 Game Preserve Road, Gaithersburg, MD 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Boyd's Presbyterian  
Church Cemetery

Date

January 14  
2008

20c. Location - City or Town, State

Boyd's, MD

21. Signature of Funeral Service Licensee

TRACY A. Jans

22. Name and Address of Facility

DeVol Funeral Home, 10 East Deer Park Drive,  
Gaithersburg, MD 2087723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Squamous cell carcinoma of the Head and Neck 6 years

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death Check only a

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 41866

29d. Date signed (Month, Day, Year)

January 10, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karan Hudhud, MD 46B Thomas Johnson Drive Frederick, MD 2102

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02516

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARIBETH R. DEMPSEY

2. Date of Death

JAN. 11, 2008

3. Time of Death

3:50 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

4521 East-West Highway, #801

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

MONTGOMERY

5. Social Security Number

577-80-6302

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

52

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

Sept. 22, 1955

9. Birthplace (State or Foreign Country)

W. VA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4521 East-West Highway, #801

10f. Zip Code

20814

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Edward V. Berard

18. Mother's Name (First, Middle, Maiden Surname)

Catherine McBrien

19a. Informant's Name/Relationship (Type, Print)

Michael Dempsey (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17822 Buehler Rd, Olney, MD 20832

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Riverdale Pk Cre

Date

1-14-2008

20c. Location - City or Town, State

Riverdale, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.

246 N. Washington St, Rockville, MD 20850

23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.

Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate  
Interval Between  
Onset and Death

a. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier  
(Check only  
one)

29b. Signature and title of certifier

29c. License number

D 31720

29d. Date signed (Month, Day, Year)

Jan. 14, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Herbert M. Juarbe, M.D. 806 W. Diamond Avem #310, Gaithersburg, MD 20877

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

Karen B. Spente

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02517

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Leonard Forman

2. Date of Death

Jan. 11, 2008

3. Time of Death

8:40 A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

117-01-4984

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90

8. Date of Birth (Month, Day, Year)

Sept. 20, 1917

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15101 Interlachen Drive #409

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: Navy WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4yr 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Patent Examiner

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Morris Forman

18. Mother's Name (First, Middle, Maiden Surname)

Rose Yampolsky

19a. Informant's Name/Relationship (Type, Print)

Sylvia M. Forman - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15101 Interlachen Dr. #409 Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Lebanon

Date

1/13/2008

20c. Location - City or Town, State

Adelphi, Maryland

21. Signature of Funeral Service Licensee

Donald C. Stettin

22. Name and Address of Facility

Edward Sagel Funeral Direction, Inc.  
1091 Rockville Pike Rockville, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Subdural Hematoma

Due to (or as a consequence of):

b. Atrial fibrillation

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

1/5/08

28b. Time of Injury

Unkn. P M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Patient fell at home in bathroom

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

At home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

#409 Silver Spring, MD 20906

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Genevieve Anne Wroblewski, MD

29c. License number

D0064615

29d. Date signed (Month, Day, Year)

January 11, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Genevieve Anne Wroblewski, MD 1355 Piccard Drive Rockville, MD 20850

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature

Genevieve Wroblewski

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036  
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/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02518

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lillie Mae Glenn

2. Date of Death

January 6, 2008

3. Time of Death

10:49a M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

5. Social Security Number

578-24-1738

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

8. Date of Birth

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth (Month, Day, Year)

01/09/1920

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4121 18th Street, N.E.

10f. Zip Code

20018

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

11

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Biological Lab Tech.

16b. Kind of Business/Industry

Healthcare/Medical

17. Father's Name (First, Middle, Last)

Robert Smith Robinson

18. Mother's Name (First, Middle, Maiden Surname)

Queen Ester Dean

19a. Informant's Name/Relationship (Type, Print)

Patricia Copelin/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9302 Alcona Street Lanham, MD 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

01/12/2008

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

Sonya Montgomery Cheatham

22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc.

3401 Bladensburg Road Brentwood, MD 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic Colon Cancer

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Heather H Davis, MD

29c. License number

M061131

29d. Date signed (Month, Day, Year)

1/06/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Heather H Davis, 8118 Good Luck Road, Lanham, MD 20706

31. Date filed (Month, Day, Year)

JAN 08 2008

32. Registrar's Signature

Heather H Davis

State Registrar

Division or Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0036

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02519

1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

LaRoi T. Hawkins

2. Date of Death

Month Day Year  
January 22, 2008

3. Time of Death

2100 hrs

4a. Facility Name (If not institution, give street and number)

7430 Calder Drive

4b. City, Town, or Location of Death

Capitol Heights

4c. County of Death

Prince George's

5. Social Security Number

220-94-3346

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

34

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

Feb. 11, 1973

9. Birthplace (State or Foreign Country)

Wash. DC

Usual Residence of Decedent

10a. State  
Md.10b. County  
P.G.10c. City, Town or Location  
Capitol Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7430 Calder Drive

10f. Zip Code

20743

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Leroy Hawkins

18. Mother's Name (First, Middle, Maiden Surname)

Bernice Allen

19a. Informant's Name/Relationship (Type, Print)

Bernice Allen- Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7430 Calder Drive Capitol Heights Md 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln

Date

Feb. 1, 08

20c. Location - City or Town, State

Brentwood, Md

21. Signature of Funeral Service Licensee

John E. Robinson

22. Name and Address of Facility

Robinson Funeral Home 1313 6th St. NW DC 20001

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiomegaly with right ventricular dilatation

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED☐ AMENDED

#23a, PII, 27, 28a-f, per ME, G877 3/11/08 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)6 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebral contusions

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation2 ☒ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

June 2006

28b. Time of Injury

unk

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Motorcycle collision

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

unk

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ana Rubi

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 23, 2008

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubi MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

JAN 28 2008

32. Registrar's Signature

Larri Thomas Hawkins

Baltimore, MD 21215-0036

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To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02520

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

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Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Blois Oliver Hundley</b>  |  | 2. Date of Death<br>Month Day Year<br><b>January 13 2008</b>   |  | 3. Time of Death<br><b>1050 M</b>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Gilchrist Center for Hospice Care</b>   |  | 4b. City, Town, or Location of Death<br><b>Towson</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |   |
| 5. Social Security Number<br><b>577-28-7789</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>September 21, 1914</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |
| Usual Residence of Decedent  |  |  |  |  |   |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Howard</b>   | 10c. City, Town or Location<br><b>Columbia</b>   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>8610 Snowden River Parkway</b>  |  | 10f. Zip Code<br><b>21045</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b>College</b>  |  |  |   |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Chef</b>   |  | 16b. Kind of Business/Industry<br><b>Private Family</b>  |  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>James Oliver Doles</b>   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edith Florence Smith</b>   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Theodosia Smith - Daughter</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1030 Cresthaven Drive, Silver Spring, Maryland 20904</b> |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>01/19/2008 Brentwood, Maryland</b>   |   |
| 21. Signature of Funeral Service Licenses<br><b>Nancy A. Perconte</b>  |  | 22. Name and Address of Facility<br><b>Hines-Rinaldi Funeral Home, Inc.<br/>11800 New Hampshire Avenue, Silver Spring, Maryland 20904</b>  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>SMALL BOWEL OBSTRUCTION</b><br>Due to (or as a consequence of):<br>b. <b>CERVICAL CANCER</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>WEEKS</b><br><b>YEARS</b> |  |  |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown                |  | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |  |  |   |
| 27. Manner of death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |   |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |  |   |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  |  |   |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |  | 29c. License number<br><b>D64395</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JANUARY 13, 2008</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DANIELLE DOBERMAN, MD 6565 N CHARLES ST, SUITE 216 BALTIMORE, MD 21204</b>  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JAN 16 2008</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |   |

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02521

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VICKY LYNN HIGGS

2. Date of Death

January 16, 2008

3. Time of Death  
1155AM

4a. Facility Name (If not institution, give street and number)

Memorial Hospital at Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

212-72-1874

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

41

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC. 13, 1966

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

QUEEN ANNE

10c. City, Town or Location

CHURCH HILL

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

318 CHURCH HILL ROAD

10f. Zip Code

21623

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4or 5+)  
616a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

NURSE

16b. Kind of Business/Industry

NURSING

17. Father's Name (First, Middle, Last)

CHARLES THOMPSON

18. Mother's Name (First, Middle, Maiden Surname)

DALE MORGAN

19a. Informant's Name/Relationship (Type, Print)

BRYAN HIGGS/ HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

318 CHURCH HILL ROAD, CHURCH HILL, MD 21623

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)  
CHESAPEAKE CREMATION  
CENTER

Date

1-17-2008

20c. Location - City or Town, State

STEVENSVILLE, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A.  
408 S. LIBERTY ST., CENTREVILLE, MD 2161723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. metastatic Breast Cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
yearsSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Congestive Heart Failure

Due to (or as a consequence of):

years

c. Malignant pleural effusion

Due to (or as a consequence of):

Months

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D 66441

29d. Date signed (Month, Day, Year)

January 16 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOLLI RAMESH 2195 WASHINGTON STREET, EASTON, MD 21601

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02522

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Michael Howard James

2. Date of Death

Jan. 23 Day 2008 Year

3. Time of Death

20:15 M

4a. Facility Name (If not institution, give street and number)

12801 Growdenvale Dr. NE

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

226-46-9993

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 2, 1938

9. Birthplace (State or Foreign Country)

Colorado

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12801 Growdenvale Dr. NE

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1957

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Clothing

17. Father's Name (First, Middle, Last)

Donnelly Trent James

18. Mother's Name (First, Middle, Maiden Surname)

Cleo (Simmons) James

19a. Informant's Name/Relationship (Type. Print)

Lorraine James Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12801 Growdenvale Dr. NE, Cumberland, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oakwood Cemetery

Date

Jan 26, 2008

20c. Location - City or Town, State

Falls Church, VA

21. Signature of Funeral Service Licensee

Wong D. Upchurch

22. Name and Address of Facility

Hafer Funeral Service, PA

1302 National Hwy., LaVale, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cirrhosis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. coronary artery disease

Due to (or as a consequence of):

15 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D36766

29d. Date signed (Month, Day, Year)

1/24/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vikramaditya Poonai, 924 Seton Dr., Cumberland, MD 21502

31. Date filed (Month, Day, Year)

JAN 31 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760, 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02523

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Christopher Johnson</b>   |  |   |  | 2. Date of Death<br>Month <u>January</u> Day <u>3</u> Year <u>2008</u>  |  | 3. Time of Death<br><u>0150</u> M  |  |
| 4a. Facility Name (If not institution, give street and number)<br><u>Fort Washington Hospital</u>  |  |   |  | 4b. City, Town, or Location of Death<br><u>Fort Washington</u>  |  | 4c. County of Death<br><u>Prince George's</u>  |  |
| 5. Social Security Number<br><u>061-50-7896</u>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><u>50</u> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><u>Dec. 26, 1957</u>  |  |
| 9. Birthplace (State or Foreign Country)<br><u>St. George, S.C.</u>  |  |   |  |   |  |  |  |
| Usual Residence of Decedent  |  |   |  |   |  |  |  |
| 10a. State<br><u>Maryland</u>  |  | 10b. County<br><u>Prince Georges</u>  |  | 10c. City, Town or Location<br><u>Ft. Washington</u>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><u>7511 Glade Dr.</u>  |  |   |  | 10f. Zip Code<br><u>20744</u>   |  | 10g. Citizen of What Country?<br><u>United States</u>  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><u>12</u>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Auto Mechanic</u>   |  | 16b. Kind of Business/Industry<br><u>Private</u>   |  |
| 17. Father's Name (First, Middle, Last)<br><u>David Johnson, Sr.</u>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Pernice Brown</u>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Pernice Johnson / Mother</u>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>9011 Cameron Ct. Clinton, Md. 20735</u>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Resurrection</u>   |  | Date<br><u>Jan. 10, 2008</u>  |  | 20c. Location - City or Town, State<br><u>Clinton, Md.</u>   |  |
| 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>  |  |   |  | 22. Name and Address of Facility<br><u>Alexander S. Pope, P.A.</u><br><u>5538 Marlboro Pike/Forestville, Md. 20747</u>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Atherosclerotic Cardiovascular Heart Disease</u><br>Due to (or as a consequence of):<br>b. <u>Due to (or as a consequence of):</u><br>c. <u>Due to (or as a consequence of):</u><br>d. <u>Due to (or as a consequence of):</u><br>Approximate Interval Between Onset and Death |  |   |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death<br><input type="checkbox"/> Unknown   |  | 3 <input type="checkbox"/> Ectopic pregnancy<br>5 <input type="checkbox"/> Other (specify)  |  | 23d. Date of delivery<br>Month <u>Jan</u> Day <u>10</u> Year <u>2008</u>   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |  |  |  |
|  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><u>[Signature]</u>  |  |   |  | 29c. License number<br><u>H0055927</u>  |  | 29d. Date signed (Month, Day, Year)<br><u>January 4, 2008</u>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Salvador S. S. 3001 Hospital Drive, Chevy Chase, Maryland</u>   |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><u>JAN 08 2008</u>  |  |   |  | 32. Registrar's Signature<br><u>[Signature]</u>   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

CR (4)

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02524

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hoo Ying Kwong

2. Date of Death

Month Day Year  
January 11, 2008

3. Time of Death

11:30p M

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

215-13-9837

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 28, 1934

9. Birthplace (State or Foreign Country)

Hong Kong

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4114 Heathfield Road

10f. Zip Code

20853

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Interior Designer

16b. Kind of Business/Industry

Home Decorating

17. Father's Name (First, Middle, Last)

Kwong Kai Ming

18. Mother's Name (First, Middle, Maiden Surname)

Mak Wan Chin

19a. Informant's Name/Relationship (Type, Print)

Siu Chui Kwong/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4114 Heathfield Road, Rockville, MD 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery 2008

Date

Jan. 16,

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.

500 University Blvd, W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 WEEKS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RIGHT HEMITHORAX HYPOPLASIA

COR PULMONALE, PAROXYSMAL ATRIAL

FIBRILLATION

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No N/A

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0058542

29d. Date signed (Month, Day, Year)

JANUARY 12, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. LJILJA HEINZ-MOMCILOVIC  
10605 CONCORD STREET # 500, KENSINGTON, MD 20895

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, 15

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02525

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Phyllis Hansen Kindley

2. Date of Death

January 10, 2008

3. Time of Death

6:35 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

415 Russell Avenue, #1102

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

577-58-3003

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

102

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 5, 1905

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

415 Russell Avenue #1102

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Humanitarian

17. Father's Name (First, Middle, Last)

Burton Hansen

18. Mother's Name (First, Middle, Maiden Surname)

Mary Antoinette Duncan

19a. Informant's Name/Relationship (Type, Print)

David Lee Colglazier (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 Moulton Drive, Londonderry, NH 03053-4000

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory 1/11/08 Alexandria, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
DeVol Funeral Home  
10 East Deer Park Drive  
Gaithersburg, Maryland 2087723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
YearsSequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Artery Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D19294

29d. Date signed (Month, Day, Year)

January 11, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John R. Melnick, M.D. 911 Russell Avenue, Gaithersburg, MD 20879

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature

John R. Melnick

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02526

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Lawson

2. Date of Death

January 13, 2008

3. Time of Death

9:50 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

214-28-3994

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 2, 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Edgewater

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

671 Loch Haven Road

10f. Zip Code

21037

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1952-54

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Lumber Company

17. Father's Name (First, Middle, Last)

John Lawson

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Jett

19a. Informant's Name/Relationship (Type, Print)

Rose Marie Lawson/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

671 Loch Haven Road Edgewater, Maryland 21037

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hillcrest Mem. Gardens 1/18/2008

Date

20c. Location - City or Town, State

Annapolis, Maryland

21. Signature of Funeral Service Licensee

Todd E. Liller

22. Name and Address of Facility

John M. Taylor Funeral Home  
147 Duke of Gloucester St., Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RENAL FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CARDIOMYOPATHY

Due to (or as a consequence of):

5 years

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

5 years

d. DIABETES MELLITUS

5 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alvin S. Madarang, MD

29c. License number

D00039166

29d. Date signed (Month, Day, Year)

01-14-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALVIN S. MADARANG 808 LANDMARK DR. STE 128, Glen Burne, MD 21061

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature

Kane to Spack

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02527

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard T. Lynch

2. Date of Death

Jan 08, 2008

3. Time of Death

7:08 p<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

9 H Queen Victoria Way

4b. City, Town, or Location of Death

Chester

4c. County of Death

Queen Anne's

5. Social Security Number

219-18-8411

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jul 22, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Queen Anne's

10c. City, Town or Location

Chester

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9 H Queen Victoria Way

10f. Zip Code

21619

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No WWII

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Air Force Officer

16b. Kind of Business/Industry

Military

17. Father's Name (First, Middle, Last)

Richard T. Lynch

18. Mother's Name (First, Middle, Maiden Surname)

Laura Bourne

19a. Informant's Name/Relationship (Type, Print)

Louise Lynch/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

209 Rushley Road Arnold, MD 21012

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

Jan. 15, 2008

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Gov. Ritchie Hwy, Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic obstructive pulmonary disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Several years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive heart failure

Due to (or as a consequence of):

Several years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ischemic cardiomyopathy

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D32353

29d. Date signed (Month, Day, Year)

January 14, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel J. Konick, M.D. 115 Sallitt Drive, Suite E Stevensville, MD 21666

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02523

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |  |   |  |   |
|---|--|--|---|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Ida Mae Hazel Lopez</b>  |  | 2. Date of Death<br>Month <b>January</b> Day <b>6</b> Year <b>2008</b>   |   | 3. Time of Death<br><b>3:39 A M</b>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Talbot Hospice</b>   |  | 4b. City, Town, or Location of Death<br><b>Easton</b>  |   | 4c. County of Death<br><b>Talbot</b>   |   |
| 5. Social Security Number<br><b>217-26-0669</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>May 19, 1928</b>              |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
| Usual Residence of Decedent   |  |  |   |  |   |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>Queen Anne</b>   | 10c. City, Town or Location<br><b>Chester</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>29-A Queen Mary Ct.</b>  |  | 10f. Zip Code<br><b>21619</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>  |   |  |   |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Receptionist</b>  |  | 16b. Kind of Business/Industry<br><b>Publishing</b>  |   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Otis Faulkner</b>   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Brooks</b> |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia A. Beville / daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>515 Skipper Ct. Chester, MD. 21619</b>   |   |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>  |   | 20c. Location - City or Town, State<br><b>01/07/2008 Alexandria, VA.</b>   |   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Beall Funeral Home</b><br><b>6512 NW Crain Hwy. Bowie, MD. 20715</b>  |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CONGESTIVE HEART FAILURE</b>  |  |  |   |  |   |
| 23b. Immediate Cause (Final disease or condition resulting in death)<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):  |  |  |   |  |   |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown   |  |  |   |  |   |
| 23d. Date of delivery<br>Month Day Year   |  |  |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |   |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>  |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |   |  |   |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |   |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D3706Y</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>1/7/08</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>James Chamberlain, MD 115 South Dr Stevensville, MD 21661</b>  |  |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JAN 08 2008</b>   |  | 32. Registrar's Signature<br>  |   |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02529

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BURTON

I.

LEVINE

2. Date of Death

Month Day Year  
JANUARY 12 2008

3. Time of Death

1145 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

096-28-1335

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

8. Date of Birth (Month, Day, Year)

Jan. 3, 1938

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

10602 Farmbrooke Lane

10f. Zip Code

20854

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No Navy  
If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Civil Engineer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

William Levine

18. Mother's Name (First, Middle, Maiden Surname)

Sadye Katz

19a. Informant's Name/Relationship (Type, Print)

Susan Levine - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10602 Farmbrooke Lane, Potomac, MD 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garden of Remembrance Cemetery

Date

01/15/2008

20c. Location - City or Town, State

Clarksburg, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Edward Sagel Funeral Direction, Inc.  
1091 Rockville Pike, Rockville, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC LUNG CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
ONE YEAR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 33686

29d. Date signed (Month, Day, Year)

JANUARY 12 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KENNETH D. MILLER MD 18111 PRINCE PHILIP DR. OLNEY MD 20832

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02530

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LEONIE F. LIDSKY

2. Date of Death  
Month Day Year

JAN. 12, 2008

3. Time of Death

5:01 P M

4a. Facility Name (If not institution, give street and number)

LAUREL REGIONAL HOSPITAL

4b. City, Town, or Location of Death

LAUREL

4c. County of Death

PRINCE GEORGE'S

Funeral  
Director

5. Social Security Number

087-18-7897

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

8. Date of Birth (Month, Day, Year)

MAR. 14, 1922

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3158 GRACEFIELD RD. APT. 505

10f. Zip Code

20904

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

MAURICE

SPAISER

18. Mother's Name (First, Middle, Maiden Surname)

FLORA

KATZ

19a. Informant's Name/Relationship (Type. Print)

SOL LIDSKY/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3158 GRACEFIELD RD. APT. 505, SILVER SPRING, MD. 20904

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

1-16-2008

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

W. W. Chambers M00091

22. Name and Address of Facility

CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.  
5801 CLEVELAND AVE., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

b. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

c. HYPERTENSION

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PULMONARY FIBROSIS

OSTEOPOROSIS

RHEUMATOID ARTHRITIS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Rachelle Alexion MD

29c. License number

D44156

29d. Date signed (Month, Day, Year)

01/15/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rachelle Alexion MD

3110 Gracefield Road Silver Spring, MD

20904

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

Brene B. Spate

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

10

1- For State  
Registrar

Certificate of Death

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Gregory D. Moore

2. Date of Death

Month Day Year  
January 25, 2008

3. Time of Death

0835 hrs

4a. Facility Name (if not institution, give street and number)

8632 Cobblefield Drive

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

255-31-9222

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

30

Yrs.

If Under 1 Year

Months Days

If Under 24Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

11/01/1977

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8632 Cobblefield Dr., #3D

10f. Zip Code

21045

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Events Coordinator

16b. Kind of Business/Industry

Baseball

17. Father's Name (First, Middle, Last)

David J. Moore

18. Mother's Name (First, Middle, Maiden Surname)

Jayne E. Saroukos

19a. Informant's Name/Relationship (Type, Print)

Jayne E. Moore/ Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

435 Penwood Drive, Edgewater, MD 21037

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Kalas Crematory

Date

1/27/08

20c. Location - City or Town, State

Edgewater, MD

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

George P. Kalas Funeral Home

2973 Solomons Island Rd. Edgewater, MD 21037

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Alcohol and zolpidem intoxication

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED

☐ AMENDED

#23a, 27, 28a-f per ME, g877 3/11/08 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy

4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☒ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

Fnd 1/25/2008

28b. Time of Injury

Fnd 8:35 am

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

unk

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) House

28f. Location (Street and Number or Rural Route Number, City or Town, State)

8632 Cobblefield Dr. Columbia, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 26, 2008

30. Name and address of person who completed cause of death (Item 23a)

Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

JAN 28 2008

32. Registrar's Signature

*[Signature]*

11489  
Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02532

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |   |  |  |
|--|--|---|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Helen J. Martin</b>   |  |   |  | 2. Date of Death<br>Month <b>1</b> Day <b>11</b> Year <b>2008</b>  |   | 3. Time of Death<br><b>1902</b> M  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>AAMC</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>   |   | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| 5. Social Security Number<br><b>213-28-5756</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs. | 8. Date of Birth (Month, Day, Year)<br><b>Jul 28, 1930</b>   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |  |
| Usual Residence of Decedent  |  |   |  |  |   |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Annapolis</b>  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>211 Winchester Beach Drive</b>  |  |   |  | 10f. Zip Code<br><b>21401</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |   | 16b. Kind of Business/Industry<br><b>Home</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Raymond Timanus</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Wiencke</b>  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dr. William F. Martin III/ Son</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>211 Winchester Beach Drive Annapolis, MD 21401</b>   |   |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>  |  | Date<br><b>Jan. 14, 2008</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Barranco &amp; Sons, P.A. Severna Park Funeral Home<br/>495 Gov. Ritchie Hwy, Severna Park, MD 21146</b>  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Syncope</b><br>Due to (or as a consequence of):<br>b. <b>Severe pulmonary hypertension</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>hours</b><br><b>unknown</b> |  |   |  |  |   |  |  |
| 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year  |  |   |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CAD, Diabetes, HTN, atrial Fibrillation</b>   |  |   |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>D0061783</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>1/11/2008</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Chang Choi, MD 2001 Medical Pkwy, Annapolis, MD 21401</b>   |  |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 15 2008</b>  |  |   |  | 32. Registrar's Signature<br>  |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



## Certificate of Death

Reg. No. 2008 02533

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Stephen C. Miller</b>   |  | 2. Date of Death<br>Month <b>January</b> Day <b>5</b> Year <b>2008</b>  |  | 3. Time of Death<br><b>3:08 P M</b>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>  |  | 4c. County of Death<br><b>Anne Arundel</b>   |   |
| 5. Social Security Number<br><b>213-42-6557</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Mar. 3, 1945</b>                       |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
| Usual Residence of Decedent  |  |   |  |  |   |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Anne Arundel</b>   | 10c. City, Town or Location<br><b>Riva</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>2813 Cedar Drive</b>  |  | 10f. Zip Code<br><b>21140</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |  |   |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Salesman</b>   |  | 16b. Kind of Business/Industry<br><b>Auto Sales</b>   |  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>James Albert Miller, Jr.</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel Gertrude Byron</b> |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Anissa M. Hastings/ daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1903 Gallant Knight Lane Mt. Airy, MD. 21771</b>  |  |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | 20c. Location - City or Town, State<br><b>1/11/2008 Alexandria, VA.</b>  |   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Beall Funeral Home</b><br><b>6512 NW Crain Hwy. Bowie, MD. 20715</b>   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |   |
| Immediate Cause (Final disease or condition resulting in death)<br><b>Acute myocardial infarction</b>  |  |   |  |  |   |
| Due to (or as a consequence of):   |  |   |  |  |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |  |   |
| Due to (or as a consequence of):   |  |   |  |  |   |
| Due to (or as a consequence of):   |  |   |  |  |   |
| IF FEMALE:   |  |   |  |  |   |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |   |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |   |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D38563</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>January 7, 2008</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Wayne Bierbaum 134 Owensville Rd, West River MD 20778</b>   |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JAN 08 2008</b>  |  | 32. Registrar's Signature<br>  |  |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #3 per PHYS 01-18-2008 ~~CNM~~ Certificate of Death

Reg. No. 2008 02534

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Peggy Dorothy Magee

2. Date of Death

JAN. 16 2008

3. Time of Death

7:10 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MARY'S HOUSE ASSISTED LIVING

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

203-24-0872

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT 16 1919

9. Birthplace (State or Foreign Country)

ENGLAND

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

POOLESVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

17813 DOCTOR WALLING RD.

10f. Zip Code

20837

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

RETAIL SALES

16b. Kind of Business/Industry

CLOTHING

17. Father's Name (First, Middle, Last)

SIDNEY ARTHUR DUNT

18. Mother's Name (First, Middle, Maiden Surname)

DOROTHY ALICE CHAPMAN

19a. Informant's Name/Relationship (Type. Print)

KARINA FLYNN / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17813 DOCTOR WALLING RD., POOLESVILLE, MD 20837

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

STAUFFER CREMATORY 1/18/08

Date

20c. Location - City or Town, State

FREDERICK, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HILTON FUNERAL HOME

P.O. BOX 86, BARNESVILLE, MD 20838

20838

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

unknown

unknown

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Osteoarthritis

Anemia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Amar V. Duggirala - Family Physician

29c. License number

#61505

29d. Date signed (Month, Day, Year)

1/17/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amar Duggirala D.O., 19710 Fisher Ave, Ste J, Poolesville MD 20837

31. Date filed (Month, Day, Year)

JAN 18 2008

32. Registrar's Signature

Amar V. Duggirala

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02535

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Leonard Arthur McCafferty

2. Date of Death

JAN. 11, 2008

3. Time of Death

1:35 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

016-24-4217

6. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
76 Yrs.8. Date of Birth (Month, Day, Year)  
NOV. 8, 19319. Birthplace (State or Foreign Country)  
Massachusetts

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Montgomery10c. City, Town or Location  
Rockville10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number

1749 Crestview Drive

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Francis A. McCafferty

18. Mother's Name (First, Middle, Maiden Surname)

Henrietta C. Simpson

19a. Informant's Name/Relationship (Type, Print)

Joyce A. Gorman - sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1749 Crestview Drive, Rockville, MD 20854

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Riverdale Park  
Crematory

Date

JAN. 12,  
2008

20c. Location - City or Town, State

Riverdale Park, MD

21. Signature of Funeral Service Licensee

► *Funeral Service Licensee*

MO1508

22. Name and Address of Facility

Thibadeau Mortuary Service, P.A.  
933 Gist Avenue, LL, Silver Spring, MD 2091023a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. MULTISYSTEM ORGAN FAILURE

Due to (or as a consequence of):

b. SEPTIC SHOCK

Due to (or as a consequence of):

c. PNEUMONIA

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury et  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

2006602

29d. Date signed (Month, Day, Year)

1/14/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Atul Rohatgi, M.D., 8600 Old Georgetown Road, Bethesda, MD 20814

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature

*Kevin L. Spotts*

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02536

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Alfred Harold Moss

2. Date of Death

Month Day Year  
January 10, 2008

3. Time of Death

8:15 P M

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

578-18-1325

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

91

8. Date of Birth

If Under 1 Year If Under 24 Hrs.  
Months Days Hours Min.

8. Date of Birth (Month, Day, Year)

July 6, 1916

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1713 Black Oak Lane

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1940-62

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Military Officer

16b. Kind of Business/Industry

United States Armed Forces

17. Father's Name (First, Middle, Last)

Alfred Lee Moss

18. Mother's Name (First, Middle, Maiden Surname)

Bena Lakes

19a. Informant's Name/Relationship (Type, Print)

Ruth U. Moss/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1713 Black Oak Lane, Silver Spring, MD 20901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cemetery

Date

Feb. 27, 2008

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

Name and Address of Facility

Francis J. Collins Funeral Home Inc.  
500 University Blvd, W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrest

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D62432

29d. Date signed (Month, Day, Year)

January 10, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Holley C. Meers, M.D. 1500 Forest Glen Road, Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02537

1- For  
State  
Registrar

|  |  |  |   |  |  |  |   |  |
|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Randall James Mariner</b>   |  |   |  | 2. Date of Death<br>Month <b>1</b> Day <b>16</b> Year <b>08</b>  |  | 3. Time of Death<br><b>6:20AM</b>                                       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Coastal Hospice At The Lake</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Salisbury</b>   |  | 4c. County of Death<br><b>Wicomico</b>                                  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-26-8480</b>  |  | 6. Sex<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>80</b>  |  | 8. Date of Birth (Month, Day, Year)<br><b>10/16/1927</b>                |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |   |  |  |  |   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |  |   |  |  |  |   |  |
|  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Worcester</b>   |  | 10c. City, Town or Location<br><b>Snow Hill</b>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|  | 10e. Street and Number<br><b>105 N. Church St.</b>   |  |   |  | 10f. Zip Code<br><b>21863</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|  | 11. Marital Status<br><b>2</b> <input checked="" type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> <input checked="" type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b><br>Elementary/Secondary (0-12) College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bus Driver</b>                                      |  | 16b. Kind of Business/Industry<br><b>Worcester County Board of Education</b>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Otho M. Mariner, Sr.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ella Gray</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joanne B. Mariner / wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>105 N. Church St., Snow Hill, MD 21863</b>   |  |   |  |
|  | 20a. Method of Disposition<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bates Cemetery</b>   |  | Date<br><b>1/19/2008</b>   |  | 20c. Location - City or Town, State<br><b>Snow Hill, MD</b>             |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>The Burbage Funeral Home</b><br><b>108 William St., Berlin, MD 21811</b>   |  |  |  |   |  |
|  | Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CHOLANGIOCARCINOMA</b><br>Due to (or as a consequence of):<br><b>b. METASTATIC LIVER CARCINOMA</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |  |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No<br><b>9</b> <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><b>1</b> <input type="checkbox"/> Live birth <b>2</b> <input type="checkbox"/> Fetal death<br><b>4</b> <input type="checkbox"/> Pregnant at time of death<br><b>5</b> <input type="checkbox"/> Other (specify)<br><b>9</b> <input type="checkbox"/> Unknown   |   |  |  | 23d. Date of delivery<br>Month _____ Day _____ Year _____  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No   |   |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)  |   |  |  |  |   |  |
| 27. Manner of Death<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>        |  | 28c. Injury at Work?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No   |   |  |
| 28d. Describe how injury occurred  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br>  |  |  |   | 29c. License number<br><b>D0058410</b> |  | 29d. Date signed (Month, Day, Year)<br><b>1/16/08</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GHUAM WARRIE COASTAL HOSPICE P.O. Box 1733 SALISBURY MD 21802</b>   |  |  |   |  |  |  |   |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>JAN 17 2008</b>  |  |   |  | 32. Registrar's Signature<br>  |  |   |  |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02538

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clifton Everett Olsen

2. Date of Death

January 15, 2008

3. Time of Death

11:45 P.M.

4a. Facility Name (If not institution, give street and number)

St. Catherines Nursing Center

4b. City, Town, or Location of Death

Emmitsburg

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

220-18-2025

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 4, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Thurmont

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14838 Old Camp Airy Road

10f. Zip Code

21788

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance Supervisor

16b. Kind of Business/Industry

Camp Grounds

17. Father's Name (First, Middle, Last)

Walter

Olsen

18. Mother's Name (First, Middle, Maiden Surname)

Zula

Eyler

19a. Informant's Name/Relationship (Type, Print)

Tim Olsen (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14838 A Old Camp Airy Road, Thurmont, MD 21788

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bethel German.Ch Cem

Date

1/21/2008

20c. Location - City or Town, State

Cascade, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Stauffer Funeral Home, PA

104 E. Main street, Thurmont, MD 21788

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End stage Parkinson's Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia  
Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

#004805

29d. Date signed (Month, Day, Year)

01-16-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dante J. KREUFEL-PORTERDO 121-123 W. Main ST Emmitsburg, MD 21721

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 18 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene


2008 02539

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Nancy Clagett O'Neill</b>   |  |   |  | 2. Date of Death<br>Month <b>January</b> Day <b>13</b> Year <b>2008</b>  |  | 3. Time of Death<br><b>6:45p</b> M   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Morningside House of Friendship</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Hanover</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| 5. Social Security Number<br><b>220-28-6736</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 13, 1934</b>                                    |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |  |  |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Hanover</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>7548 Old Telegraph Road</b>   |  |   |  | 10f. Zip Code<br><b>21076</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b><br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph Donald Clagett</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Barron</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jacqueline Goldberg/Daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>813 Thicket Court, Odenton, Maryland 21113</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Mark Episcopal Cemetery</b>                                      |  | Date<br><b>Jan. 17, 2008</b>   |  | 20c. Location - City or Town, State<br><b>Silver Spring, Maryland</b>                          |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home Inc.<br/>500 University Blvd, W., Silver Spring, MD 20901</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Chronic obstructive pulmonary disease years</b>  |  |   |  |  |  |  |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown   |  |   |  |  |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |  |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Assisted Living</b>   |  |   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
| 28d. Describe how injury occurred  |  |   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br> MD  |  |   |  | 29c. License number<br><b>D50725</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>1-14-2008</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jennifer Kiedinger 8601 Veterans Hwy Millersville MD 21108</b>  |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 15 2008</b>  |  |   |  | 32. Registrar's Signature<br>   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

02540

## State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

|  |  |   |  |  |   |   |   |  |  |
|--|--|---|--|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Emily Marie Olson</b>                     |   |  |  | 2. Date of Death<br>Month <b>January</b> Day <b>10</b> Year <b>2008</b> |   | 3. Time of Death<br><b>10:25p</b> M                         |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1001 Lanark Way</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>            |   | 4c. County of Death<br><b>Montgomery</b>                    |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-14-3352</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs.                        |   | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 26, 1911</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Michigan</b>                              |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Silver Spring</b>         |  |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>1001 Lanark Way</b>   |   | 10f. Zip Code<br><b>20901</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>Emanuel Krans</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Annie Johnson</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Gerald W. Olson/Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1001 Lanark Way, Silver Spring, MD 20901</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parklawn Memorial Park</b>   |   | 20c. Location - City or Town, State<br><b>Rockville, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home Inc.<br/>500 University Blvd, W, Silver Spring, MD 20901</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Advanced Alzheimer's Disease</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   | Approximate Interval Between Onset and Death<br><b>Years</b>  |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown                   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>Vuivamaditya D. Reddy MD</b>   |  |
| 29c. License number<br><b>D 43464</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>JANUARY-14-2008</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>VIKRAMADITYA D REDDY, 1112 ROCKVIEW PIKE, SUITE 208, ROCKVILLE, MD-20852</b>  |   | 31. Date filed (Month, Day, Year)<br><b>JAN 15 2008</b>   |   | Registrar's Signature<br>  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02541

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Patrick O'Leary

2. Date of Death

Month Day Year  
January 14, 2008

3. Time of Death

7:20 a M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

578-30-9893

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 25, 1926

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Highland

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

13550 Clarksville Pike

10f. Zip Code

20777

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Public Information Official

16b. Kind of Business/Industry

N.A.S.A.

17. Father's Name (First, Middle, Last)

Jeremiah A. O'Leary

18. Mother's Name (First, Middle, Maiden Surname)

Kathleen Tobin

19a. Informant's Name/Relationship (Type, Print)

Sarah M. O'Leary/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13550 Clarksville Pike, Highland, MD 20777

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Louis Cemetery

Date

Jan. 18,  
2008

20c. Location - City or Town, State

Clarksville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.

500 University Blvd., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

cardio respiratory arrest

b. Due to (or as a consequence of):

sepsis

c. Due to (or as a consequence of):

G.I. bleeding

d. Due to (or as a consequence of):

Renal failure

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death  
☐ Pregnant at time of death  
☐ Unknown☐ Ectopic pregnancy  
☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an  
autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

60999

29d. Date signed (Month, Day, Year)

1/15/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARUNA PASUPALA MD

MGH, 18101, Prince of Wales Dr.  
Olney, MD 20832

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02542

1- For  
State  
Registrar

|  |   |  |  |  |   |   |  |  |
|--|---|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>MELVIN RENO POOLE                                 |  |  |  | 2. Date of Death<br>Month JANUARY Day 14, Year 2008 |   | 3. Time of Death<br>10:19 A M                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>FREDERICK MEMORIAL HOSPITAL |  |  |  | 4b. City, Town, or Location of Death<br>FREDERICK   |   | 4c. County of Death<br>FREDERICK                   |  |
| Funeral<br>Director  | 5. Social Security Number<br>220-76-7189  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>46 Yrs.           |   | 8. Date of Birth (Month, Day, Year)<br>May 1, 1961 |  |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland  |  | 10a. State<br>Maryland   |  | 10b. County<br>Frederick                            |   | 10c. City, Town or Location<br>Frederick           |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 10e. Street and Number<br>214 Linden Avenue  |  | 10f. Zip Code<br>21703   |   | 10g. Citizen of What Country?<br>United States  |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 0 College (1-4or 5+) 0  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Helper  |  | 16b. Kind of Business/Industry<br>Shelter Workshop   |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br>Unknown   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Maryann Poole   |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Susan Holton/ Friend   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>620-B Research Drive, Frederick, Maryland 21703   |   |   |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Stauffer Crematory Inc 1/17/08   |  | 20c. Location - City or Town, State<br>Frederick, Maryland   |   |   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |  |  | 22. Name and Address of Facility<br>Stauffer Funeral Home P. A.<br>1621 Opossumtown Pike, Frederick, MD 21702  |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Seizure disorder<br>Due to (or as a consequence of):<br>Mental retardation<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Due to (or as a consequence of): |   |  |  |  |   |   |  |  |
| Approximate Interval Between Onset and Death<br>yr yr  |   |  |  |  |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown   |  | 23d. Date of delivery<br>Month Day Year  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  | 28d. Describe how injury occurred  |   |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |   |   |  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |  |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br>  |   |  |  | 29c. License number<br>015804  |   | 29d. Date signed (Month, Day, Year)<br>1-16-08  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>STEVEN PICKERT 180 Thomas Johnson Drive, Frederick, Maryland 21702   |   |  |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>JAN 18 2008   |   |  |  | 32. Registrar's Signature<br>  |   |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02543

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

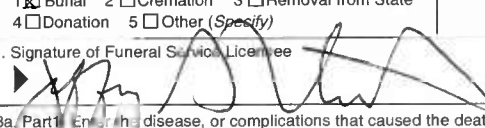
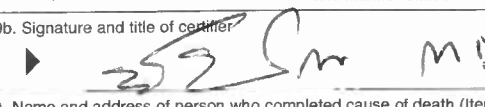

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                             |  |   |  |   |  |  |  |  |  |  |
|-----------------------------|--|---|--|---|--|--|--|--|--|--|
| Physician /Medical Examiner |  | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Charles Powell</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>January 13, 2008</b>  |  | 3. Time of Death<br><b>1:00 P<sup>M</sup></b>  |  |  |
| Funeral Director            |  | 4a. Facility Name (If not institution, give street and number)<br><b>7628 Miller Fall Road</b>  |  | 4b. City, Town, or Location of Death<br><b>Derwood</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |  |  |  |  |
|                             |  | 5. Social Security Number<br><b>216-34-4520</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb 24, 1937</b>   |  |  |
|                             |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Derwood</b>  |  |  |
|                             |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>7628 Miller Fall Road</b>  |  | 10f. Zip Code<br><b>20855</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |
|                             |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
|                             |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>-</b> College (1-4or 5+) <b>3</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Design Engineer</b>   |  | 16b. Kind of Business/Industry<br><b>I.B.M.</b>  |  |  |  |  |
|                             |  | 17. Father's Name (First, Middle, Last)<br><b>Marion Otis Powell</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Elizabeth Millar</b>  |  |  |  |  |
|                             |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Sandra Virginia Powell (Wife)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7628 Miller Fall Road, Derwood, Maryland 20855</b>                                       |  |  |  |  |
|                             |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>All Souls Cemetery</b>   |  | Date<br><b>January 16, 2008</b>  |  | 20c. Location - City or Town, State<br><b>Germantown, Maryland</b>   |  |  |
|                             |  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877</b>  |  |  |  |  |  |  |
|                             |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Aspiration Pneumonia</b><br>Due to (or as a consequence of):<br><b>Cerebrovascular Accident</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  | Approximate Interval Between Onset and Death |  |
|                             |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |  |
|                             |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b>  |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|                             |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |  |
|                             |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
|                             |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|                             |  | 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |  |  |
|                             |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |  |  |
|                             |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |  |
|                             |  | 29b. Signature and title of certifier<br> MD   |  |   |  | 29c. License number<br><b>D62435</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>January 14, 2008</b>   |  |  |
|                             |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sayed M. Elsayyad, M.D., 9715 Medical Center Drive, #201, Rockville, MD 20850</b>  |  |   |  |  |  |  |  |  |
|                             |  | 31. Date filed (Month, Day, Year)<br><b>JAN 15 2008</b>   |  |   |  | 32. Registrar's Signature<br>   |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02544

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ADELINE MARY PINO

2. Date of Death

Month Day Year  
JANUARY 12 2008

3. Time of Death

20:00 M

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

161-10-7856

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 20, 1913

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Montgomery Village

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19109 Caprhart Drive

10f. Zip Code

20886

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Guistano Perazza

18. Mother's Name (First, Middle, Maiden Surname)

Theresa Muse

19a. Informant's Name/Relationship (Type, Print)

Maria Pino Kingston (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19109 Capehart Dr. Montgomery Village, MD 20886

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Cross Cemetery

Date

January 18, 2008

20c. Location - City or Town, State

Yeadon. PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr. Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA WITH LEFT PLEURAL EFFUSION

Due to (or as a consequence of):

day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Escherichia coli urinary tract infection

Due to (or as a consequence of):

days

c. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

days

d. DEMENTIA

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

00065830

29d. Date signed (Month, Day, Year)

JANUARY 13 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMIE MORANO MD 9901 MEDICAL CENTER DRIVE ROCKVILLE, MD 20850

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02545

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ernest Bernard Pierce

2. Date of Death

January 11 2008

Day

Year

3. Time of Death

21:53 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Peninsula Regional Medical Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

217-30-7875

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 25, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Talbot

10c. City, Town or Location

Easton

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

10 Village Street Apt. 111

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Food Processing

17. Father's Name (First, Middle, Last)

Richard Bowser, JR.

18. Mother's Name (First, Middle, Maiden Surname)

Mildred v. Pierce

19a. Informant's Name/Relationship (Type, Print)

Theona Hall

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

304 Appleby School Rd. Cambridge, MD. 21613

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chapel Cemetery

Date

1/18/08

20c. Location - City or Town, State

Easton, Maryland

21. Signature of Funeral Service Licensee

Janelle C. Henry

22. Name and Address of Facility

Henry Funeral Home, P.A.

510 Washington St. Cambridge, MD. 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

ASCD

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death

9 Unknown

3 Ectopic pregnancy

5 Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 Outpatient

3 DOA

26. Place of Death (Check only one)

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Chris Snyder

29c. License number

H50497

29d. Date signed (Month, Day, Year)

1/14/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chris Snyder 100 E. Carroll St. Salisbury MD 21801

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02546

1- For State Registrar

|  |   |   |   |  |  |   |  |
|--|---|---|---|--|--|---|--|
| Physician / Medical Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT RODGERS</b>   |   |   | 2. Date of Death<br>Month <b>01</b> Day <b>10</b> Year <b>08</b>   |  | 3. Time of Death<br><b>1015</b> M   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1278 Robert Road</b>   |   |   | 4b. City, Town, or Location of Death<br><b>Crownsville</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>  |  |
| Funeral Director   | 5. Social Security Number<br><b>170-12-4132</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>09/20/1916</b>                                       |
|  | 9. Birthplace (State or Foreign Country)<br><b>Glasgow, PA</b>  |   |   |  |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Crownsville</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|  | 10e. Street and Number<br><b>1278 Robert Road</b>   |   |   | 10f. Zip Code<br><b>21032</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII</b><br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Mechanic</b>  |  | 16b. Kind of Business/Industry<br><b>Metro</b>   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Roy Rodgers</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Esther Hamilton</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Eleanor Rodgers</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1278 Robert Road Crownsville, MD 21032</b> |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Suitland</b>  |  | Date<br><b>01/14/2008</b>  |   | 20c. Location - City or Town, State<br><b>Suitland, MD</b>                                     |
|  | 21. Signature of Funeral Service Licensee<br><b>Batal A</b>   |   |   | 22. Name and Address of Facility<br><b>Hardesty Funeral Home P.A. 12 Ridgely Ave Ann, MD 21401</b>   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>STROKE</b><br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of): <b>HTN</b><br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br><b>60 DAYS</b><br><b>year</b> |   |   |  |  |   |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input checked="" type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |   |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 28d. Describe how injury occurred  |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |   |  |
| 29b. Signature and title of certifier<br><b>Michael J. Lentano</b>   |   | 29c. License number<br><b>D 21438</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>January 11, 2008</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MICHAEL J. LENTANO 445 DEFENSE HWY ANNAPOLIS MD 21401</b>   |   |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 15 2008</b>  |   | 32. Registrar's Signature<br><b>James H. Spaul</b>  |   |  |  |   |  |

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02547

1- For  
State  
Registrar

|   |  |                               |   |  |  |  |   |   |  |  |
|---|--|-------------------------------|---|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner                       | 1. Decedent's Name (First, Middle, Last)<br><b>Carrie Mae Russell</b>  |                               |   |  | 2. Date of Death<br>Month <b>01</b> Day <b>12</b> Year <b>2008</b>   |  |   |   | 3. Time of Death<br><b>21:43pm</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b>   |                               |   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |  |   |   | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director                                     | 5. Social Security Number<br><b>579-34-0487</b>  |                               | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>08/29/29</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>N.C.</b>  |  |
|   | Usual Residence of Decedent  |                               |   |  |  |  |   |   |  |  |
| To Be Completed by Funeral Director                     | 10a. State<br><b>DC</b>  |                               | 10b. County<br><b>None</b>  |  | 10c. City, Town or Location<br><b>Washington</b>   |  |   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>5326 Rock Creek Church Road</b>   |                               |   |  | 10f. Zip Code<br><b>20010</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)  |                               |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk</b>  |  |   | 16b. Kind of Business/Industry<br><b>Federal Government</b>             |  |  |
| To Be Completed by Physician/Medical Examiner           | 17. Father's Name (First, Middle, Last)<br><b>Robert Taylor</b>  |                               |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Virginia McQueen</b>   |  |   |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Teri Russell Salley Daughter</b>  |                               |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3404 Brinkley Rd #102 Temple Hills, Md 20748</b>   |  |   |   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glenwood Cemetery</b>  |  | 20c. Date<br><b>01/10/08</b>   |  | 20d. Location - City or Town, State<br><b>Washington, DC</b>  |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |                               |   |  | 22. Name and Address of Facility<br><b>Snead Mortuary Service, P.A.<br/>1409 Fairlakes Pl Ste B Mitchellville, Md 20721</b>  |  |   |   |  |  |
| Physician<br>/Medical<br>Examiner                       | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>SEPSIS</b>   |                               |   |  |  |  |   |   | Approximate Interval Between Onset and Death   |  |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                               |   |  |  |  |   |   |  |  |
|   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |                               |   |  |  |  |   |   | 23d. Date of delivery<br>Month Day Year  |  |
|   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |                               |   |  |  |  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner           | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                               | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No           |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |                               | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                               |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                               |   |  |  |  |   |   |  |  |
| State Registrar   | 29b. Signature and title of certifier<br>  |                               |   |  | 29c. License number<br><b>H0064588</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>1-14-08</b>   |   |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ashish Tolia, M.D. 1500 Forest Glen Road Silver Spring, Md 20910</b>  |                               |   |  |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 16 2008</b> |  | 32. Registrar's Signature<br> |   |  |  |  |   |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

|   |   |   |   |  |  |  |
|---|---|---|---|--|--|--|
| Physician/<br>Medical Examiner  | 1. For State Registrar  | Reg. No.  |   |  |  |  |
|   | 1. Decedent's Name (First, Middle, Last)<br>WILLIAM CECIL RHINAMAN  |   | 2. Date of Death<br>Month Day Year<br>January 24, 2008  | 3. Time of Death<br>0506 hrs   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Frederick Memorial Hospital   |   | 4b. City, Town, or Location of Death<br>Frederick   | 4c. County of Death<br>Montgomery  |  |  |
|   | 5. Social Security Number<br>217-08-1941  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>32 Yrs.   | 8. Date of Birth (MM/DD/YYYY)<br>MARCH 1, 1975   | 9. Birthplace (State or Foreign Country)<br>WEST VIRGINIA    |  |
| Funeral Director  | Usual Residence of Decedent   |   |   |  |  |  |
|   | 10a. State<br>MARYLAND  | 10b. County<br>WASHINGTON   | 10c. City, Town or Location<br>KNOXVILLE  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
|   | 10e. Street and Number<br>19111 VALLEY OVERLOOK COURT   |   | 10f. Zip Code<br>21758  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                                   |  |  |
| To Be Completed by Funeral Director   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>LINESMAN   |  | 16b. Kind of Business/Industry<br>ELECTRIC UTILITY CO.       |  |
|   | 17. Father's Name (First, Middle, Last)<br>CHARLES WILLIAM RHINAMAN   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>DIANNE MARIE AULT  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>TARA A. RHINAMAN/SPOUSE   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>19111 VALLEY OVERLOOK COURT, KNOXVILLE, MD 21758   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>BROWNSVILLE HGTS CEM.   | Date<br>1/28/2007  | 20c. Location - City or Town, State<br>BROWNSVILLE, MARYLAND |  |
| Physician /Medical Examiner   | 21. Signature of Funeral Service Licensee<br>Paul M. Dean   |   | 22. Name and Address of Facility<br>BAST FUNERAL HOME<br>Boonsboro, Maryland 21713  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) a. Cardiac arrhythmia<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. cardiomegaly<br>Due to (or as a consequence of):<br>c. left ventricular hypertrophy<br>Due to (or as a consequence of):<br>d.<br>#PI liane a-c, 27 per ME, 877, 3/3/08 TT |   |   |  | Approximate Interval Between Onset and Death                 |  |
|   | <input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED   |   |   |  |  |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year                      |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:          |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| State Registrar   | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  |  |  |
|   | 29b. Signature and title of certifier<br>Zabiullah Ali, M.D. Assistant Medical Examiner   |   | 29c. License number<br>O.C.M.E.   |  | 29d. Date signed (Month, Day, Year)<br>January 25, 2008      |  |
| 30. Name and address of person who completed cause of death (Item 23a)<br>Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JAN 31 2008  |   |   |   |  |  |  |
| 32. Registrar's Signature   |   |   |   |  |  |  |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02549

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Mary Crocker Sayers

2. Date of Death

January 25, 2008

3. Time of Death

2:15 PM

4a. Facility Name (If not institution, give street and number)

15 Kline Blvd.

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

149-64-5178

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 30, 1961

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15 Kline Blvd.

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

+6

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Vice President/Trust

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

Phil Crocker

18. Mother's Name (First, Middle, Maiden Surname)

Margot Kloss

19a. Informant's Name/Relationship (Type, Print)

Kevin Sayers, husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 Kline Blvd., Frederick, MD 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mount Olivet Cemetery Jan. 29, 2008 Frederick, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

MO0255

22. Name and Address of Facility

Keeney and Basford PA Funeral Home  
106 East Church St., Frederick, MD 2170123a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. BREAST CANCER, METASTATIC

Approximate  
Interval Between  
Onset and Death

OVER 2 YRS

9/2004

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

016675

29d. Date signed (Month, Day, Year)

JAN. 28, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. McGUIRE, Brunswick, MD 21716

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 31 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02550

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

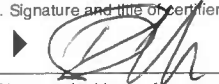

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Elizabeth E. Smith</b>  |  | 2. Date of Death<br>Month <b>January</b> Day <b>12</b> , Year <b>2008</b>  |  | 3. Time of Death<br><b>6:30 A M</b>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Fairfield Nursing Home</b>  |  | 4b. City, Town, or Location of Death<br><b>Crownsville</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>   |   |
| 5. Social Security Number<br><b>222-14-2760</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>March 22, 1926</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Delaware</b> |
| Usual Residence of Decedent  |  |  |  |  |   |
| 10a. State<br><b>Delaware</b>  | 10b. County<br><b>Kent</b>   | 10c. City, Town or Location<br><b>Smyrna</b>   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>120 North Main Street</b>   |  | 10f. Zip Code<br><b>19977</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>XX</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Associate Editor</b>   |   |
| 16b. Kind of Business/Industry<br><b>Publishing</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Samuel Ennis</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorcus Deakyne</b>   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Creadick Smith/Son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>120 North Main Street, Smyrna, Delaware 19977</b>  |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Old Fellows Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Smyrna, Delaware 19977</b>   |   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>George P. Kalas Funeral Home<br/>2973 Solomons Island Road, Edgewater, Md. 21037</b>  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cerebrovascular Accident</b><br>Due to (or as a consequence of):<br>b. _____<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month _____ Day _____ Year _____  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia</b>  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)<br>_____   |  | 28b. Time of Injury<br>M _____   |   |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |
| 29b. Signature and title of certifier<br> MD  |  | 29c. License number<br><b>D38958</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>1/12/2008</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Doreen Smith Smith MD 208 Gram Highway SW Glen Burnie MD 21061</b>  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JAN 15 2008</b>  |  | 32. Registrar's Signature<br>   |  |  |   |

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02551

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clarence Lee Suggs

2. Date of Death

January 4, 2008

3. Time of Death

12:31 a M

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-64-1832

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

8. Date of Birth (Month, Day, Year)

Oct. 25, 1946

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8722 Brae Brooke Dr.

10f. Zip Code

20706

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chief Mail Services

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Clarence Lee Suggs, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Margaret McAllister

19a. Informant's Name/Relationship (Type, Print)

Ernestine W. Suggs / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8722 Brae Brooke Dr. Lanham, Md. 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Washington National

Date

1/11/2008

20c. Location - City or Town, State

Suitland, Md.

21. Signature of Funeral Service Licensee

▶ *Keith A. Suggs* 0101085

22. Name and Address of Facility

Alexander S. Pope & P.A.  
5538 Marlboro Pike/Forestville, Md. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOPULMONARY ARREST

Due to (or as a consequence of):

b. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

c. HYPERTENSION

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

▶ *Dr. Suggs MD*

29c. License number

D46529

29d. Date signed (Month, Day, Year)

JANUARY 4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VICTOR ONYESIAKA 7325A HANOVER PARKWAY GREENBELT MARYLAND 20740

31. Date filed (Month, Day, Year)

JAN 08 2008

32. Registrar's Signature

*Keith A. Suggs*State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02552

1- For State Register MEND#768, per FH, 1/18/08, DPS, MCo

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Albert H. Small

2. Date of Death

Month Day Year  
January 13, 2008

3. Time of Death

10:05 a<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

7119 Braeburn Place

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

132-03-5310

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

-67- 88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 1919  
Dec. 02, 1920

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7119 Braeburn Place

10f. Zip Code

20817

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Economist

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

William Small

18. Mother's Name (First, Middle, Maiden Surname)

Rebecca Jaffa

19a. Informant's Name/Relationship (Type, Print)

Jeffrey R. Small /Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

171 Druid Drive, McMurray, PA 15317

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

Judean Memorial Gardens Jan. 14, 2008

20c. Location - City or Town, State

Olney, MD

21. Signature of Funeral Service Licensee

Ralph E. Williams, Jr.

22. Name and Address of Facility

Hines-Rinaldi Funeral Home, Inc.  
11800 New Hampshire Ave., Silver Spring, MD 2090423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Non-Hodgkins Lymphoma

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Anemia

Due to (or as a consequence of):

c. Sepsis

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Katherine E. David, D.O.

29c. License number

H0055125

29d. Date signed (Month, Day, Year)

January 13, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Katherine E. David, D.O. 5530 Wisconsin Ave., Suite 1149, Chevy Chase, MD 20815

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature

Katherine E. David

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

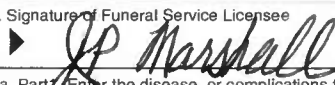
## Certificate of Death

Reg. No.

2008 02553

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director



To Be Completed by Funeral Director

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>TERRY PAULETTE STEPP</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>JANUARY 1, 2008</b>   |  | 3. Time of Death<br>M<br><b>10:00p</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>National Institutes of Health</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| 5. Social Security Number<br><b>237-17-9738</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>46</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>April 5, 1961</b>                                    |  |
| 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>   |  | Usual Residence of Decedent   |  |  |  |  |  |
| 10a. State<br><b>NC</b>   |  | 10b. County<br><b>Henderson</b>   |  | 10c. City, Town or Location<br><b>Hendersonville</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>292 Hobe Crest Road</b>  |  |   |  | 10f. Zip Code<br><b>28792</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12th</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Unemployed</b>                    |  | 16b. Kind of Business/Industry<br><b>None</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Lawrence Stepp</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maxine Case</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Maxine Stepp/Mother</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>292 Hobe Crest Road Hendersonville, NC 28792</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Shepherds Park</b>   |  | Date<br><b>01-06-2008</b>  |  | 20c. Location - City or Town, State<br><b>Hendersonville, NC</b>                               |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Marshall's Funeral Home, Inc.<br/>4217 9th Street, NW Washington, DC 20011</b>                             |  |  |  |  |  |

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Klebsiella septic shock</b><br>Due to (or as a consequence of):<br><b>b. neutropenia</b><br>Due to (or as a consequence of):<br><b>c. acute leukemia</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  | Approximate Interval Between Onset and Death<br><b>days</b><br><b>days</b><br><b>years</b>   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
|   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
|   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |
| 29b. Signature and title of certifier<br> MD   |  | 29c. License number<br><b>Massachusetts License #227870</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>1/1/08</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JASON ELINOFF 10 CENTER DRIVE, BETHESDA, MD 20892</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 08 2008</b>   |  | 32. Registrar's Signature<br>  |  |  |  |

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02554

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Earl Reece Stadtman

2. Date of Death

January 7, 2008

3. Time of Death

9:30 a M

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

557-28-9821

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 15, 1919

9. Birthplace (State or Foreign Country)

New Mexico

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Derwood

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

16907 Redland Road

10f. Zip Code

20855

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 Yes 2 No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: Caucasian

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Biochemist

16b. Kind of Business/Industry

Biomedical Research

17. Father's Name (First, Middle, Last)

Walter William Stadtman

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Ethyl Reece

19a. Informant's Name/Relationship (Type, Print)

Thressa C. Stadtman - spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16907 Redland Road, Derwood, Maryland 20855

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Ft. Lincoln Crematory

Date

1/17/2008

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Simple Tribute Funeral and Cremation Center  
1040 Rockville Pike, Rockville, Maryland 2085223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Malignant Arrhythmia

Due to (or as a consequence of):

b. Atherosclerotic Heart Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 Yes 2 No  
9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy  
4 Pregnant at time of death 5 Other (specify)  
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an  
autopsy  
performed?

1 Yes 2 No

24b. Were autopsy findings available  
prior to completion of cause of  
death?

1 Yes 2 No

25. Was case referred to medical  
examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation  
2 Accident 6 Could not be  
3 Suicide 4 Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

1 Yes 2 No

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D00065955

29d. Date signed (Month, Day, Year)

1/7/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yogin Patel 9901 Medical Center Drive, Rockville, Maryland 20850

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

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once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02555

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorathy Freund Simmons

2. Date of Death

JAN. 13, 2008

3. Time of Death

8:15 A.<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

524 Hawkesbury Lane

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

052-38-7511

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

8. Date of Birth (Month, Day, Year)

JAN. 22, 1912

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

524 Hawkesbury Lane

10f. Zip Code

20904

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Freund

18. Mother's Name (First, Middle, Maiden Surname)

Edna Roman

19a. Informant's Name/Relationship (Type, Print)

Jane Brecher, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

524 Hawkesbury Lane, Silver Spring, MD 20904

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Funeral Service

Date

1/14/2008

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

► *Ernest S. Oser*

M01508

22. Name and Address of Facility

Thibadeau Mortuary Service, P.A.  
933 Gist Ave., LL, Silver Spring, MD 20910

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

5 Years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Depression

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death Check only one

Other: 4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician:2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► *Ernest S. Oser, M.D.*

29c. License number

D0003792

29d. Date signed (Month, Day, Year)

1/14/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ernest S. Oser, M.D. 10301 Georgia Ave., Ste 304 Silver Spring, MD 20902

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature

*Ernest S. Oser*

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02556

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |   |  |                                 |  |  |   |  |
|--|--|---|---|--|---------------------------------|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Carolyn Lee Shade</b>   |  |   | 2. Date of Death<br>Month Day Year<br><b>January 12, 2008</b>   |  |                                 | 3. Time of Death<br><b>6:40p M</b>   |  |   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |  |                                 | 4c. County of Death<br><b>Montgomery</b>   |  |   |  |
| 5. Social Security Number<br><b>228-60-4008</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.   |                                 | 8. Date of Birth (Month, Day, Year)<br><b>April 28, 1944</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |  |
| Usual Residence of Decedent  |  |   |   |  |                                 |  |  |   |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Takoma Park</b>  |                                 |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>7611 Maple Avenue, #204</b>   |  |   | 10f. Zip Code<br><b>20912</b>   |  |                                 | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                 |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b><br><b>College (1-4or 5+) 12</b>   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Mental Health Technician</b>  |  |                                 | 16b. Kind of Business/Industry<br><b>Mental Health Facility</b>  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Eugene Shade</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nadine Martha Lee</b>  |                                 |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Lisa R. Snip/Daughter</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9923 Killarney Lane, #203, Gaithersburg, MD 20877</b>                                    |                                 |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  |                                 | 20c. Location - City or Town, State<br><b>Jan. 14, 2008 Alexandria, Virginia</b>   |  |   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home Inc.<br/>500 University Blvd, W., Silver Spring, MD 20901</b>   |                                 |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cardiopulmonary Arrest</b><br>Due to (or as a consequence of):<br>b. <b>Metastatic Lung Cancer</b><br>Due to (or as a consequence of):<br>c. <b>Pleural Effusion</b><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |                                 |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |                                 | 23d. Date of delivery<br>Month Day Year  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |                                 | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                 |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b> |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |  |
|  |  |   | 28d. Describe how injury occurred   |  |                                 | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
|  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |                                 |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |                                 |  |  |   |  |
| 29b. Signature and title of certifier<br>  |  |   |   | 29c. License number<br><b>D0066162</b>   |                                 | 29d. Date signed (Month, Day, Year)<br><b>1-12-2008</b>  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Edith N. Aniedobie, MD 1500 Forest Glen Road, Silver Spring, MD 20901</b>   |  |   |   |  |                                 |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 15 2008</b>  |  |   |   | 32. Registrar's Signature<br>  |                                 |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02557

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Virginia Schaake

2. Date of Death

January 15, 2008

3. Time of Death

9:30 a.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

5504 Bonnie Brook Road

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

579-42-3308

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 1, 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5504 Bonnie Brook Road

10f. Zip Code

21613

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

secretary

16b. Kind of Business/Industry

law office

17. Father's Name (First, Middle, Last)

Thomas Wiltshire

18. Mother's Name (First, Middle, Maiden Surname)

Martha Dunn

19a. Informant's Name/Relationship (Type, Print)

Ronald E. Schaake husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5504 Bonnie Brook Rd., Cambridge, MD 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cem.

Date

1/22/08

20c. Location - City or Town, State

Hurlock, MD

21. Signature of Funeral Service Licensee

B. K. R.

22. Name and Address of Facility

Thomas Funeral Home P.A.

700 Locust St., Cambridge, MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic ovarian Cancer

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. J. R. MD

29c. License number

D 47924

29d. Date signed (Month, Day, Year)

1-16-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOMAN THAWNY 503 BYRN ST CAMBRIDGE MD 21613

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

ne 2008 02558

3. Time of Death  
640 A M

ANNE ARUNDEL

Glen Burni

10d. Inside City Limits

USA

Specify: **Black**

Private

Unknown

81 West 4th St., Pottstown, PA 19464

Washington, DC

3821 - 14th Street, N.W., DC 20011

Approximate  
Interval Between  
Onset and Death

b. \_\_\_\_\_  
Due to (or as a consequence of):

c. \_\_\_\_\_  
Due to (or as a consequence of):

23d. Date of delivery  
Month      Day      Year

1 ☐ Yes    2 ☒ No    3 ☐ Probably    4 ☐ Unknown

er. 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**MAGNETIC RECORDS**

1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

200. Date signed (Month, Day, Year)  
JANUARY 11, 2008

BRIAN C. WALLACE, MD, 9005 KALBRIDE RD, BALTIMORE, MD 21236

Allen B. Spauld

ORIGINAL




Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02559

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>EMORY LEE THORNE JR.</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>01 22 2008</b>  |  | 3. Time of Death<br><b>2200 M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>WMHS-BRADDOCK CAMPUS</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>  |  | 4c. County of Death<br><b>ALLEGANY</b>   |  |
| 5. Social Security Number<br><b>232-21-7237</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>44</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 18, 1963</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Romney, WV</b>  |  |   |  |  |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |  |  |
| 10a. State<br><b>WV</b>  |  | 10b. County<br><b>Mineral</b>   |  | 10c. City, Town or Location<br><b>Burlington</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>HC 84, Box 91-A</b>   |  |   |  | 10f. Zip Code<br><b>26710</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1982-86</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Self Employed Truck Driver</b>   |  | 16b. Kind of Business/Industry<br><b>Trucking</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Emory L. Thorne, Sr.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Shirley J. Faulk</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Tamera L. Thorne/Wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>HC 84, Box 91-A Burlington, WV 26710</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Elijah High Cemetery</b>   |  | Date<br><b>Jan. 26 2008</b>  |  | 20c. Location - City or Town, State<br><b>Purgitsville, WV</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Smith Funeral Home</b>   |  | 85 S. Main Street<br><b>Keyser, WV 26726</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Refractory Lymphoma</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br><b>32 months</b> |  |   |  |  |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  |   |  |  |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D0023371</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>1/23/2008</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Qamar ul Zaman MD</b><br><b>Cumberland MD 21502</b>   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 31 2008</b>  |  |   |  | 32. Registrar's Signature<br>   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760, 44

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02560

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Joseph Toomey

2. Date of Death

Jan 10, 2008

3. Time of Death

5:41 P M

4a. Facility Name (If not institution, give street and number)

Household of Angels Assisted Living

4b. City, Town, or Location of Death

Severna park

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

084-24-6019

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

75

8. Date of Birth (Month, Day, Year)

Mar 01, 1932

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

505 Green Forest Drive

10f. Zip Code

21146

10g. Citizen of What Country?

USA &amp; Ireland

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1955-

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Industrial Sales Representative

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

William Joseph Toomey Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Florence Taylor

19a. Informant's Name/Relationship (Type, Print)

Amanda Kathleen Gartner/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

627 Cypresspointe Drive Severna Park, MD 21146

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

Jan. 18, 2008

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

*James E. Barranco*

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Gov. Ritchie Hwy, Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Astrocytoma Brain tumor*

Approximate Interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)*Asst. Living*

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Paul B. Berenz MD*

29c. License number

D 0029571

29d. Date signed (Month, Day, Year)

01/14/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*Paul B. Berenz MD 2225 E Defense Hwy, Crofton, MD 21114*State  
Registrar

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature

*Karen H. Smith*

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02561

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

An Minh Truong Tang

2. Date of Death

January 8, 2008

3. Time of Death

6:43pm<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

18409 Hallmark Court

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

220-94-5300

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Oct. 5, 1932

9. Birthplace (State or Foreign Country)

Vietnam

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18409 Hallmark Court

10f. Zip Code

20879

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Asian

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

17. Father's Name (First, Middle, Last)

Toan Truong

18. Mother's Name (First, Middle, Maiden Surname)

Sinh Dang

19a. Informant's Name/Relationship (Type, Print)

Derek Tang (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11121 Maryland Manor Court, Germantown, MD 20876

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

National Memorial Park 1/11/08

Falls Church, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Drive

Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Non-Small Cell Lung Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Arati Desai, Medical Doctor

29c. License number

D64677

29d. Date signed (Month, Day, Year)

January 9, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arati Desai, M.D. 400 N. Broadway, Baltimore, MD 21231

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature

Bryan H. Sparte

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 02562  
Certificate of Death1- For  
State  
Registrar

Reg. No.

|  |   |   |  |   |  |  |  |   |
|--|---|---|--|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Constance Tilley</i>                               |   |  |   | 2. Date of Death<br>Month Day Year<br><i>January 10 2008</i> |  | 3. Time of Death<br><i>2:35 PM</i>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Wilson Healthcare Center</i> |   |  |   | 4b. City, Town, or Location of Death<br><i>Gaithersburg</i>  |  | 4c. County of Death<br><i>Montgomery</i>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><i>579-60-3598</i>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>89</i> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Mths.<br>Hours Min.                              | 8. Date of Birth (Month, Day, Year)<br><i>May 4, 1918</i>  |  | 9. Birthplace (State or Foreign Country)<br><i>CT</i>     |
|  | Usual Residence of Decedent   |   |  |   |  |  |  |   |
| 10a. State<br><i>MD</i>  |   | 10b. County<br><i>Montgomery</i>  |  | 10c. City, Town or Location<br><i>Gaithersburg</i>  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><i>301 Russell Avenue</i>  |   |   |  | 10f. Zip Code<br><i>20877</i>   |  | 10g. Citizen of What Country?<br><i>United States</i>  |  |   |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>                            |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><i>5</i>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Police Women</i>  |  | 16b. Kind of Business/Industry<br><i>D.C. Metropolitan Police</i>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><i>Harold Lee Tilley</i>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Rose Mildred Carver</i>   |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Ann Franklin / Cousin</i>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>181 Pokorny Road, Higganum, CT 06441</i>  |  |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Ashland Cemetery</i>   |  | Date<br><i>January 16 2008</i>   |  | 20c. Location - City or Town, State<br><i>Ashland, ME</i> |
| 21. Signature of Funeral Service Licensee<br><i>Tracy A. Stue</i>  |   |   |  | 22. Name and Address of Facility<br><i>DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877</i>  |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>Advanced Dementia</i><br>Due to (or as a consequence of):<br>a. _____<br>b. _____<br>c. _____<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |  |  |  | Approximate Interval Between Onset and Death              |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |   |   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                         |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |   |  |  |  |   |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |   |   |  | 29c. License number<br><i>D0059423</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>January 10 2008</i>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Nadine Feinberg 301 Russell Ave Gaithersburg, MD 20877</i>  |   |   |  |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><i>JAN 15 2008</i>  |   |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |   |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23e or 28a-f show any injury or other traumatic event, this Medical Examiner's Certificate must be completed once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1-

For  
State  
Registrar

AMEND#23a(a/b/c) per MD, 1/15/08, BW, MDC

## Certificate of Death

Reg. No.

2008 02563

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |   |  |
|---|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JOSEPH LAWRENCE NORMAN VIOLETTE</b>  |  | 2. Date of Death<br>Month <b>JAN</b> Day <b>02</b> Year <b>2008</b>   |   | 3. Time of Death<br><b>3:42 A<sup>M</sup></b>  |
| 4a. Facility Name (If not institution, give street and number)<br><b>NATIONAL NAVAL MEDICAL CENTER</b>  |  | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>   |   | 4c. County of Death<br><b>MONTGOMERY</b>   |
| 5. Social Security Number<br><b>007-28-6301</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>75</b>   | 8. Date of Birth (Month, Day, Year)<br><b>August 24, 1932</b> | 9. Birthplace (State or Foreign Country)<br><b>Maine</b>   |
| 10a. State<br><b>Virginia</b>   |  | 10b. County<br><b>Fairfax</b>   |   | 10c. City, Town or Location<br><b>McLean</b>   |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>6927 Tyndale Street</b>  |   |  |
| 10f. Zip Code<br><b>22101</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>6/14/60-12/31/76</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>5+</b>                                     |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Consulting</b>  |  | 16b. Kind of Business/Industry<br><b>Electrical Engineering</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Harvey Maurice Violette</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alice Emma Veilleux</b>   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Elizabeth H. Violette (Wife)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6927 Tyndale St., McLean, VA 22101</b>                                |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National Cemetery 2/8/08</b>   |   | 20c. Location - City or Town, State<br><b>Arlington, Virginia</b>  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Murphy Falls Church Funeral Home<br/>1102 W. Broad St., Falls Church, VA 22046</b>   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>RENAL FAILURE</b><br>Due to (or as a consequence of):<br>b. <b>DIABETIC FOOT INFECTION</b><br>Due to (or as a consequence of):<br>c. <b>DIABETES MELLITUS</b><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |
| 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |  |   |   |  |
| 23d. Date of delivery<br>Month Day Year   |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |   |   |  |
| 28a. Date of Injury (Month, Day Year)<br><b>6/14/60</b>   |  |   |   |  |
| 28b. Time of Injury<br><b>M</b>   |  |   |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |
| 28d. Describe how injury occurred   |  |   |   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |
| 29b. Signature and title of certifier<br>  |  |   |   |  |
| 29c. License number<br><b>D0064058</b>  |  |   |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>01/03/2008</b>  |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID R. WHITTAKER, LCDR, MC, USN NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD 20889</b>  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 15 2008</b>   |  |   |   |  |
| 32. Registrar's Signature<br>  |  |   |   |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02564

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Billy Ward

2. Date of Death  
Month Day Year

1 13 08 5pm M

3. Time of Death

4a. Facility Name (If not institution, give street and number)

A A M C

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

213227644

6. Sex

10 M 2 F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

06/14/1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Somerset

10c. City, Town or Location

Crisfield

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

320 Pine St.

10f. Zip Code

21817

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No 1944-

If Yes, Give Year or Dates: 1966

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Cryptologist

16b. Kind of Business/Industry

Military

17. Father's Name (First, Middle, Last)

Issac Thomas Ward

18. Mother's Name (First, Middle, Maiden Surname)

Emma Adams

19a. Informant's Name/Relationship (Type, Print)

Eleanor K. Ward Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

320 Pine St. Crisfield, MD 21817

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory

Date

1/15/2008

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Bally

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Ave. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Gram Negative Klebsiella

Due to (or as a consequence of):

c. Enterocutaneous Fistula.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

3 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death

9 Unknown

3 Ectopic pregnancy

5 Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia.

Infra-renal Aortic Aneurysm.

Dehydration.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

Inpatient

2 ER/Outpatient

3 DOA

26. Place of Death Check one

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jury Herbert

2001 Medical Plaza

Annapolis, Md. 21401

State Registrar

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature

Kean B. Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02565

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Nevada Wagstaff

2. Date of Death

January 5th 2008

3. Time of Death

8:43 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

233-62-7149

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

8. Date of Birth (Month, Day, Year)

9-15-1939

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

17 54th St. SE

10f. Zip Code

20019

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Med. Tech.

16b. Kind of Business/Industry

Health

17. Father's Name (First, Middle, Last)

Amos Jones

18. Mother's Name (First, Middle, Maiden Surname)

Quillar Mae Scales

19a. Informant's Name/Relationship (Type, Print)

Steven E. Wagstaff/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4230-B Indianhead Hgwy., Indianhead, MD 20640

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Crem.

Date

1-10-08

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

Steven A. Casper

22. Name and Address of Facility

Ft. Lincoln Funeral Home  
3401 Bladensburg Rd., Brentwood, MD 20722

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOPULMONARY Collapse

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PNEUMONIA

Due to (or as a consequence of):

days

c. BRONCHOGENIC CARCINOMA

Due to (or as a consequence of):

years

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

K. Michael Kucars

29c. License number

D52865

29d. Date signed (Month, Day, Year)

January 5th 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. Michael Kucars 3001 Hospital Drive, Cheverly MD

31. Date filed (Month, Day, Year)

JAN 08 2008

32. Registrar's Signature

Steven A. Casper

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02566

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine B. Wade

2. Date of Death  
Month Day Year

January 4, 2008

3. Time of Death

12:44 a<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince Georges

5. Social Security Number

225-60-6770

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Feb. 17, 1944

9. Birthplace (State or Foreign Country)

Suffolk, Va.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Forestville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1218 Iron Forge Rd.

10f. Zip Code

20747

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

High School Counselor

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Charlie Byrd

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Daniels

19a. Informant's Name/Relationship (Type, Print)

Alphonso Wade, Jr. /Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1218 Iron Forge Rd. Forestville, Md. 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial

Date

Jan. 10, 2008

20c. Location - City or Town, State

Landover, Md.

21. Signature of Funeral Service Licensee

Alexander S. Pope P.A.

22. Name and Address of Facility

5538 Marlboro Pike/Forestville, Md. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Advanced Multiple Myeloma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

R. F. M.D.

29c. License number

D43446

29d. Date signed (Month, Day, Year)

1.4.08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBTAN FARAHIFAR M.D. 9801 Georgia Ave Smt 3-41 Silver Spring MD 20902

31. Date filed (Month, Day, Year)

JAN 08 2008

32. Registrar's Signature

James H. Spiller

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

cf (3)

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02567

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |   |  |  |   |  |
|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Lillian Ruan Wiles</b>   |  | 2. Date of Death<br>Month <b>January</b> Day <b>15</b> Year <b>2008</b>  |   | 3. Time of Death<br><b>2:00 P<sup>M</sup></b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Golden Living Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>   |   | 4c. County of Death<br><b>Frederick</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-28-8802</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 18, 1927</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Frederick</b>  |   | 10c. City, Town or Location<br><b>Frederick</b>  |
|  | 10d. Street and Number<br><b>10608C Bethel Road</b>   |  | 10f. Zip Code<br><b>21702</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>College</b>         |   |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Peter Isaac Gilbert</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel Ruan Stull</b>   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>David L. Wiles / Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10538 Powell Road Thurmont, Maryland 21788</b> |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resthaven Mem Gardens</b>   |   | 20c. Location - City or Town, State<br><b>Frederick, Maryland</b>  |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Stauffer Funeral Homes, P.A.<br/>1621 Opossumtown Pike Frederick, Maryland 21702</b>                        |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><b>RENAL FAILURE</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  |  |   |  |
| 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |   |  |  |   |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown   |   |  |  |   |  |
| 23d. Date of delivery<br>Month Day Year  |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |  |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  |  |   |  |
| 28a. Date of Injury (Month, Day Year)  |   |  |  |   |  |
| 28b. Time of Injury<br><b>M</b>  |   |  |  |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |   |  |
| 28d. Describe how injury occurred  |   |  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |   |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |   |  |
| 29b. Signature and title of certifier<br>  |   |  |  |   |  |
| 29c. License number<br><b>D 47951</b>  |   |  |  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>01-16-2008</b>   |   |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SIBTE A. KAZMI, MD 814 TOLL HOUSE AVE. FREDERICK MD 21701</b>   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 18 2008</b>  |   |  |  |   |  |
| 32. Registrar's Signature<br>  |   |  |  |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2008 02568

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |   |  |
|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Dora WEITZMAN</b>   |  | 2. Date of Death<br>Month Day Year<br><b>January 13, 2008</b>   |   | 3. Time of Death<br><b>5:25 P M</b>  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Sligo Creek Nursing Center</b>  |  | 4b. City, Town, or Location of Death<br><b>Takoma Park</b>  |   | 4c. County of Death<br><b>Montgomery</b>   |
| 5. Social Security Number<br><b>579-26-2479</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>June 22, 1923</b> | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>  |
| Usual Residence of Decedent  |  |   |   |  |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Montgomery</b>   | 10c. City, Town or Location<br><b>Silver Spring</b>   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
| 10e. Street and Number<br><b>1131 University Blvd., W., #1505</b>  |  | 10f. Zip Code<br><b>20902</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:        |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>  |  | 16b. Kind of Business/Industry<br><b>Navy</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph Edlovitch</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Musa Edlovitz</b>   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Harry Weitzman, Husband</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20902</b><br><b>1131 University Blvd., W., #1505, Silver Spring, MD</b>  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Judean Memorial Gardens</b>  |   | 20c. Location - City or Town, State<br><b>01/16/08 Olney, MD</b>   |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Torchinsky Hebrew Funeral Home</b><br><b>254 Carroll St., NW, Washington, DC 20012</b>   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Olivopontine Cerebellar Degeneration</b>  |  | Approximate Interval Between Onset and Death<br><b>3 Years</b>  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.  |  |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D 22309</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>January 15, 2008</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Phillip W. Poth, M.D., 8712 Maywood Avenue, Silver Spring, MD 20910</b>   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 15 2008</b>  |  | 32. Registrar's Signature<br>   |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02569

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Julia Jean Waters

2. Date of Death

January 14, 2008

3. Time of Death

8:26 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

339-09-4954

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

8. Date of Birth

Oct. 3, 1917

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9500 East Light Drive

10f. Zip Code

20903

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Dorchik

18. Mother's Name (First, Middle, Maiden Surname)

Sophia Micek

19a. Informant's Name/Relationship (Type, Print)

Bernard J. Waters/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9500 East Light Drive, Silver Spring, MD 20903

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify)

entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

Jan. 19, 2008

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.

500 University Blvd. W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Urosepsis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death Check only one

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D63343

29d. Date signed (Month, Day, Year)

January 15, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Irina Ruban, MD 1500 Forest Glen Road, Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02570

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Peter Zmitrovich

2. Date of Death  
Month Day Year

JANUARY 15, 2008

3. Time of Death

0130 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Brooke Grove Assisted Living

4b. City, Town, or Location of Death

Sandy Spring

4c. County of Death

Montgomery

5. Social Security Number

109-18-7986

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 19, 1924

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15311 Beaverbrook Court, 3H

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Structural

17. Father's Name (First, Middle, Last)

Constantine Zmitrovich

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Shlopak

19a. Informant's Name/Relationship (Type, Print)

Mary Zmitrovich/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15311 Beaverbrook Court, 3H, Silver Spring, MD 20906

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

Jan. 16

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.

500 University Blvd, W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

MINUTES

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

VASCULAR DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Assisted Living

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

and Attending Physician

29c. License number

D42046

29d. Date signed (Month, Day, Year)

January 15, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Grace Brooke Huffman, M.D. 18100 Slade School Road Sandy Spring, Maryland 20860

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02571

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET ATKINS

2. Date of Death

January 30 2008

3. Time of Death

08:30AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Hospice

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

5. Social Security Number

171-18-0701

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

2/11/1915

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Pikesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4508 Coffee Tree Court

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Beautician

16b. Kind of Business/Industry

Cosmetology

17. Father's Name (First, Middle, Last)

Ambrose Chatman

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Burleigh

19a. Informant's Name/Relationship (Type, Print)

Harold Atkins/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4508 Coffee Tree Ct. Pikesville, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Restland Lincoln Men

Date

2/6/08

20c. Location - City or Town, State

Monroeville, PA

21. Signature of Funeral Service Licensee

Jank L. Lull MO1401

22. Name and Address of Facility

Vaughn C. Greene Funeral Svc.  
8728 Liberty Rd. Randallstown, MD 2113323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ADVANCED DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
YEARS

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown  
3 ☐ Ectopic pregnancy  
5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ENDOMETRIAL MASS, VAGINAL BLEEDING

FAILURE TO THRIVE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

R. Ranganathan MD

29c. License number

DS4288

29d. Date signed (Month, Day, Year)

January 30 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramaswamy I. Ranganathan

Northwest Hospital Center

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

John B. Smith

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, Ex. 2  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
document.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner




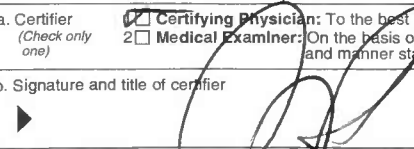

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02572

1- For State Registrar

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Hilda Augustine</b>   |  | 2. Date of Death<br>Month <b>January</b> Day <b>30</b> , Year <b>2008</b>   |  | 3. Time of Death<br><b>10:01 P<sup>M</sup></b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>3944 Link Avenue</b>  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>206-16-4828</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 8, 1924</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |  | Usual Residence of Decedent   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Baltimore</b>   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>3944 Link Avenue</b>  |  | 10f. Zip Code<br><b>21236</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                          |  |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Robert Walburn</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Verna Jane Gillaugbauer</b>   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carol A. Augustine Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3944 Link Avenue Baltimore, Maryland 21236</b>    |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore Maryland</b>   |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Road Towson, Maryland 21204</b>                                   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br><b>CAD<br/>HTN<br/>COPD<br/>Diabetes</b> |  |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)  |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>042736</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>1-31-08</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>AYMAN F. AKKAD, 7600 OSLER DR, #411, TOWSON, MD 21204</b>   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>  |  | 32. Registrar's Signature<br>   |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02573

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |   |  |  |  |   |  |  |  |   |  |
|--|---|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Yvonne (nmn) Adams  |  |  |  | 2. Date of Death<br>Month Day Year<br>January 25, 2008  |  |  |  | 3. Time of Death<br>9:15 A M  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>411 Sugarberry Ct.  |  |  |  | 4b. City, Town, or Location of Death<br>Edgewood  |  |  |  | 4c. County of Death<br>Harford  |  |
| Funeral<br>Director  | 5. Social Security Number<br>231-14-2228  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>86 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Dec. 18, 1921 |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania  |  |
|  | Usual Residence of Decedent   |  |  |  | 10a. State<br>Maryland  |  | 10b. County<br>Harford                               |  | 10c. City, Town or Location<br>Edgewood   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 10e. Street and Number<br>411 Sugarberry Ct.  |  |  |  | 10f. Zip Code<br>21040  |  |
|  | 10g. Citizen of What Country?<br>USA  |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
|  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)  |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Office Assistant   |  |  |  | 16b. Kind of Business/Industry<br>Health Care   |  |  |  | 17. Father's Name (First, Middle, Last)<br>Harvey (UNK) Harmon  |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mildred (UNK) Watson   |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br>Linda A. Baker/ Daughter  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>411 Sugarberry Ct., Edgewood, MD 21040   |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hilltop Service Corp  |  |  |  | 20c. Location - City or Town, State<br>1-28-08 Towson, Maryland   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |  |  | 22. Name and Address of Facility<br>McComas Funeral Home, P.A.<br>1317 Cokesbury Rd., Abingdon, MD 21009  |  |  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Congestive Heart Failure<br>Due to (or as a consequence of):<br>b. Coronary Artery Disease<br>Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Hypertension<br>Hyperlipidemia  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |   |  |  | 28a. Date of Injury (Month, Day Year)  |   |  |  | 28b. Time of Injury<br>M   |   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  | 28d. Describe how injury occurred  |   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  | 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  | 29b. Signature and title of certifier<br><i>[Signature]</i> MD   |   |  |
| 29c. License number<br>D0039258  |   |  |  | 29d. Date signed (Month, Day, Year)<br>Jan. 25, 2008   |   |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Lawrence D. White MD 615 W. MacPhail #206 Bel Air MD 21014 |   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 01 2008   |   |  |  | 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |  |  |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, Ky.

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02574

1- For State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Javan Brown

2. Date of Death

Month Day Year  
January 15, 2008

3. Time of Death

2127 hrs

4a. Facility Name (if not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

216-54-1374

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

6/29/1951

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State  
MD10b. County  
N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3902 Penhurst Ave. Apt. A

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12<sup>th</sup> grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborman

16b. Kind of Business/Industry

Contractor

17. Father's Name (First, Middle, Last)

George Long

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Brown

19a. Informant's Name/Relationship (Type, Print)

Javan Brown, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5434 Cedonia Ave, Baltimore, MD 21206

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Crematory

Date

2/2/08

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

John S. Smith M01401

22. Name and Address of Facility

Vaughn C. Greene Funeral Svc  
8728 Liberty Rd. Randallstown MD 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration of food bolus  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute alcohol intoxication

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

Jan 15, 2008

28b. Time of Injury

0000 hrs

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) House

28d. Describe how injury occurred

Subject choked

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3902 Penhurst Avenue, Baltimore, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Tasha Greenberg MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 16, 2008

30. Name and address of person who completed cause of death (Item 23a)

Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

Javan B. Smith

State Registrar

Baltimore, MD 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02575

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Louis John Breitenother, Sr.

2. Date of Death

Jan. 31, 2008

3. Time of Death

7:15 A M

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

219-22-5627

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 2, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8820 Walther Blvd. Apt. 4110

10f. Zip Code

21234

10g. Citizen of What Country?

United States of America

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☒ Yes ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Materials Specialist

16b. Kind of Business/Industry

Civilian Employed

US Coast Guard

17. Father's Name (First, Middle, Last)

Frederick Charles Breitenother

18. Mother's Name (First, Middle, Maiden Surname)

Matilda Johanna Lang

19a. Informant's Name/Relationship (Type, Print)

Florence Breitenother Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8820 Walther Blvd. Apt. 4110 Parkville, MD., 21234

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lake View Memorial Park

Date

Feb. 4, 2008

20c. Location - City or Town, State

Sykesville, Maryland

21. Signature of Funeral Service Licensee

Patricia M. Slaughter

22. Name and Address of Facility

EVANS FUNERAL CHAPEL & CREMATION SERVICES  
8800 Harford RD., Parkville MD., 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary FIBROSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

b. ASBESTOSIS

Due to (or as a consequence of):

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No☐ Yes ☐ No☐ Yes ☐ No

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown☐ Ectopic pregnancy☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☒ Other (Specify)

Hospice

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D64395

29d. Date signed (Month, Day, Year)

January 31, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIELLE DOBERMAN, MD 6565 N. Charles ST. Suite 209 BALTIMORE, MD 21204

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

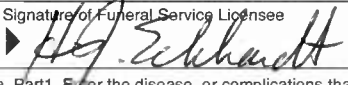

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02576

1- For  
State  
Registrar

|   |   |                              |   |   |  |  |  |  |   |  |
|---|---|------------------------------|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Grace T. Brown</b>                             |                              |   | 2. Date of Death<br>Month <b>JANUARY</b> Day <b>30<sup>th</sup></b> Year <b>2008</b>  |  |  | 3. Time of Death<br><b>5:37 PM</b>   |  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SAINT AGNES HOSPITAL</b> |                              |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  |  | 4c. County of Death  |  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-30-9691</b>   |                              | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Apr. 14, 1933</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|   | Usual Residence of Decedent   |                              |   |   |  |  |  |  |   |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Howard</b> |   | 10c. City, Town or Location<br><b>Ellicott City</b>   |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>9951 Oaklea Court</b>  |   |                              |   | 10f. Zip Code<br><b>21042</b>   |  | 10g. Citizen of What Country?<br><b>United States of America</b>             |  |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |                              | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)   |   |                              |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b> |  |  | 16b. Kind of Business/Industry<br><b>Real Estate</b>   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Ralph H. Thomas</b>   |   |                              |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clair B. Kessler</b> |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Albert Brown (Husband)</b>   |   |                              |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9951 Oaklea Court, Ellicott City, Maryland 21042</b>   |  |  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |                              | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest Veterans Cemetery</b>  |   | Date<br><b>Feb. 7, 2008</b>  |  | 20c. Location - City or Town, State<br><b>Owings Mills, Maryland</b>   |  |   |  |
| 21. Signature of Funeral Service Licensee<br>  |   |                              |   |   | 22. Name and Address of Facility<br><b>Eckhardt Funeral Chapel, P.A.<br/>11605 Reisterstown Road, Owings Mills, MD 21117</b>   |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>PNEUMONIA</b><br>Approximate Interval Between Onset and Death<br><b>DAYS</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>BREAST CANCER</b><br><b>YEARS</b> |   |                              |   |   |  |  |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |   |                              | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)                                       |   |  |  | 23d. Date of delivery<br>Month Day Year  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ANEMIA</b><br><b>ATRIAL FIBRILLATION</b>   |   |                              |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                              | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                              | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |                              | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                           |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                              | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |                              |   |   |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br><b>Garima Chaturvedi MD</b>  |   |                              |   |   | 29c. License number<br><b>P-1994</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>January 30<sup>th</sup> 2008</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Garima Chaturvedi, 909 South Caton Avenue, Baltimore, MD, 21229</b>  |   |                              |   |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>   |   |                              | 32. Registrar's Signature<br>  |   |  |  |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21266-0760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

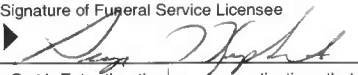
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02577

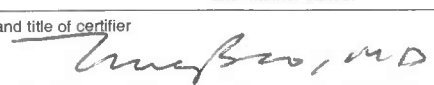

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |  |  |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Mary L. Brown</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>January 28, 2008</b>  |  |   |  | 3. Time of Death<br><b>1:30AM</b> M  |  |   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Carriage Hill Bethesda</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>  |  |   |  | 4c. County of Death<br><b>Montgomery</b>   |  |   |  |
| 5. Social Security Number<br><b>479-22-4994</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>May 10, 1925</b>                  |  | 9. Birthplace (State or Foreign Country)<br><b>Iowa</b>  |  |   |  |
| Usual Residence of Decedent   |  |   |  |  |  |   |  |  |  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Bethesda</b>   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |  |
| 10e. Street and Number<br><b>5015 Battery Lane #1004</b>  |  |   |  | 10f. Zip Code<br><b>20814</b>  |  |   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Registered Nurse</b>   |  |   |  | 16b. Kind of Business/Industry<br><b>Health Care</b>   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Harold D. Lamb</b>  |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jesse Woodroffe</b> |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dean K. Brown/ Husband</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5015 Battery Lane #1004, Bethesda, Maryland 20814</b>                                    |  |   |  |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>   |  |   |  | Date<br><b>January 30, 2008</b>  |  | 20c. Location - City or Town, State<br><b>Silver Spring, Maryland</b> |  |
| 21. Signature of Funeral Service Licensee<br> <b>M00335</b>  |  |   |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501</b>                                   |  |   |  |  |  |   |  |

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>VENTRICULAR FIBRILLATION</b>   |  |  |  | Approximate Interval Between Onset and Death  |  |
| Due to (or as a consequence of):  |  |  |  |   |  |
| 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>CONGESTIVE HEART FAILURE</b>  |  |  |  |   |  |
| Due to (or as a consequence of):  |  |  |  |   |  |
| Due to (or as a consequence of):  |  |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  |  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |
| 23d. Date of delivery<br>Month Day Year   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |  |
|   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                      |  | 28d. Describe how injury occurred   |  |
|   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)                           |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |   |  |
| 29b. Signature and title of certifier<br> <b>MD</b>  |  | 29c. License number<br><b>D0057124</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>1/29/08</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Truong Bao. M.D. 9715 Medical Center Drive #201, Rockville, Maryland 20850</b>   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>   |  | 32. Registrar's Signature<br> |  |   |  |

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, City

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02578

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Marjorie Jeanne Brett</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>January 29, 2008</b>  |  | 3. Time of Death<br><b>11:20 PM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Rockville Nursing Home</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>   |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| 5. Social Security Number<br><b>125-12-5867</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>June 12, 1918</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>New York</b>   |  |   |  |  |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Chevy Chase</b>  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>3513 Leland Street</b>   |  |   |  | 10f. Zip Code<br><b>20815</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:       |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Code Room Tech</b>   |  | 16b. Kind of Business/Industry<br><b>United States Department of the Navy</b>                      |  |
| 17. Father's Name (First, Middle, Last)<br><b>Albert F. Hess</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jeanne Madeleine Staebler</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Elizabeth G. Brett / Daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3513 Leland Street, Chevy Chase, Maryland 20815</b>  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium</b>   |  | Date<br><b>January 31, 2008</b>  |  | 20c. Location - City or Town, State<br><b>Bethesda, Maryland</b>                                   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501</b> |  |  |  |  |  |

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Hypertensive Heart Disease</b><br>Due to (or as a consequence of):<br>b. <b>Myocardial Infarction</b><br>Due to (or as a consequence of):<br>c. <b>Congestive Heart Failure</b><br>Due to (or as a consequence of):<br>d. <b>Atrial Fibrillation</b> |  |   |  | Approximate Interval Between Onset and Death   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|  |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  |
|  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D0047330</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>January 30, 2008</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Thomas Joseph, M.D. 50 West Edmonston Drive, #207, Rockville, Maryland 20852</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>  |  | 32. Registrar's Signature<br>   |  |  |  |

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02579

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |   |  |  |  |  |
|---|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Frank Tucker Bobst</b>   |   | 2. Date of Death<br>Month <b>January</b> Day <b>23</b> Year <b>2008</b>  |  | 3. Time of Death<br><b>9:00 PM</b> M   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Heron Point Nursing &amp; Rehab</b>  |   | 4b. City, Town, or Location of Death<br><b>Chestertown</b>   |  | 4c. County of Death<br><b>Kent</b>   |  |
| 5. Social Security Number<br><b>034-12-7056</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>Aug 8, 1923</b>  | 9. Birthplace (State or Foreign Country)<br><b>Massachusetts</b>                               |  |
| Usual Residence of Decedent   |   |  |  |  |  |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>Kent</b>  | 10c. City, Town or Location<br><b>Chestertown</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>810 S. Meadowview Drive</b>  |   | 10f. Zip Code<br><b>21620</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><b>unk</b><br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>'42-44</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+) <b>0</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>artist</b> |  | 16b. Kind of Business/Industry<br><b>arts</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Frank Tucker Bobst Sr</b>   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helene Hardy</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ron Barber/executor</b>  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>611 S. Leithgow Street Philadelphia, PA 19147</b>  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |  | 20c. Location - City or Town, State  |  |
| 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>  |   | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>                 |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>PANCREATIC CARCINOMA</b>  |   |  |  |  | Approximate Interval Between Onset and Death   |
| 23b. Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   |  |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death<br><input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Other (specify)   |   |  |  |  | 23d. Date of delivery<br>Month Day Year  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
|   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                |  | 28d. Describe how injury occurred  |  |
|   |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)                                     |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |
| 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |  |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>   |   | 29c. License number<br><b>D0060301</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>1/25/08</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael Bimonte 1225 Park Rd 5705 Chestertown, MD</b>  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>   |   | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
 amend #31 Per DVR G876 2/01/08 JH  
 Certificate of Death

2008 02580

1- For State Registrar

Reg. No.

Physician /Medical Examiner

Funeral Director

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>Kenneth Bowles   |  | 2. Date of Death<br>Month Day Year<br>January 18, 2008  |   | 3. Time of Death<br>10:49 PM   |  |
| 4a. Facility Name (If not institution, give street and number)<br>1022 Spa Road  |  | 4b. City, Town, or Location of Death<br>Annapolis   |   | 4c. County of Death<br>Anne Arundel  |  |
| 5. Social Security Number<br>unk   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>64 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>May 13, 1943 |  | 9. Birthplace (State or Foreign Country)<br>Maryland |
| Usual Residence of Decedent  |  |   |   |  |  |
| 10a. State<br>MD   |  | 10b. County<br>Anne Arundel   |   | 10c. City, Town or Location<br>Annapolis   |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |  |  |
| 10e. Street and Number<br>1022 Spa Road  |  | 10f. Zip Code<br>21401  |   | 10g. Citizen of What Country?<br>USA   |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:        |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: white   |  |   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>unk  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>laborer  |   | 16b. Kind of Business/Industry<br>farming  |  |
| 17. Father's Name (First, Middle, Last)<br>Philip T. Bowles  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth L. Burch   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Hattie A. Morgan/sister  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 854 Mechanicsville, MD 20659  |   |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |   | 20c. Location - City or Town, State  |  |
| 21. Signature of Funeral Service Licensee<br>Ronald S. Wade, Director  |  | 22. Name and Address of Facility<br>State Anatomy Board 655 W. Baltimore Street<br>Baltimore, MD 21201  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Cardiopulmonary arrest</u><br>Due to (or as a consequence of):<br>b. <u>20 MYOCARDIAL infarction</u><br>Due to (or as a consequence of):<br>c. <u>20 ASCVD</u><br>Due to (or as a consequence of):<br>d. _____ |  |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>DDDM</u>  |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |  |  |
| 29b. Signature and title of certifier<br><u>[Signature]</u>  |  | 29c. License number<br><u>32567</u>   |   | 29d. Date signed (Month, Day, Year)<br><u>1/24/08</u>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>2200 Dykense Hwy Ste. 200 Crofton, MD 21114</u>   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><u>1/24/08 FEB 01 2008</u>  |  | 32. Registrar's Signature<br><u>[Signature]</u>   |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02581

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Randolph Brown

2. Date of Death

JANUARY 28, 2008

3. Time of Death

0750 M

4a. Facility Name (If not institution, give street and number)

University Specialty Hospital

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

219-10-1996

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

September 25, 1925

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3201 Hillsdale Road

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 12-27-43 10-27-51

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Pastor

16b. Kind of Business/Industry

Church

17. Father's Name (First, Middle, Last)

Robert Brown

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Coleman

19a. Informant's Name/Relationship (Type, Print)

Bertha Brown/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3201 Hillsdale Rd. Baltimore, MD 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

2-2-08

20c. Location - City or Town, State

Woodlawn, MD

21. Signature of Funeral Service Licensee

Joseph D. Dyett, Jr.

22. Name and Address of Facility

Compassion Funeral Services Leroy D. Dyett, Jr. P.A. 119-121 S Stricker St. Baltimore MD 21223

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Kidney Disease  
Coronary Artery Disease  
Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph D. Dyett, Jr.

29c. License number

D43830

29d. Date signed (Month, Day, Year)

1/28/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

University Specialty Hospital

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

CHARLES BROWN

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02582

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

MARGARET K. BENNETT

2. Date of Death

Month Day Year  
JANUARY 28, 2008

3. Time of Death

11:17 P<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

HEARTHOMES

4b. City, Town, or Location of Death

LINTHICUM

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

175.01.0006

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

91

8. Date of Birth

If Under 1 Year  
Months Days Hours Min.

If Under 24 Hrs.

8. Date of Birth

(Month, Day, Year)

APRIL 20, 1916

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

CROWNSVILLE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

612 TOPLAND DR.

10f. Zip Code

21032

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JOHN KORNOSKY

18. Mother's Name (First, Middle, Maiden Surname)

MARY KRUPPA

19a. Informant's Name/Relationship (Type, Print)

JAMES BENNETT

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

612 TOPLAND DR. CROWNSVILLE, MD. 21032

20a. Method of Disposition

☒ Burial ☐ Cremation ☒ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BELLE VERNON CEMETERY

Date

2.2.2008

20c. Location - City or Town, State

BELLE VERNON, PA

21. Signature of Funeral Service Licensee

K. GREGORY FINK

M01148

22. Name and Address of Facility

FINK FUNERAL HOME, P.A. t/a MARYLAND MORTUARY SUPPORT  
426 CRAIN HWY S. GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

YEARS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown☐ Ectopic pregnancy☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

History of Bilateral pulmonary emboli  
History of cerebrovascular disease

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation☐ Accident☐ Suicide☐ Homicide☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D33231

29d. Date signed (Month, Day, Year)

JANUARY 29, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IAN K. SLEPIAN, MD 8028 RITCHIE HWY PASADENA, MD 21122

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02583

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CONCETTA M. BELLESTRI

2. Date of Death

Month Day Year  
JANUARY 30, 2008

3. Time of Death

3:05 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HART HERITAGE

4b. City, Town, or Location of Death

STREET

4c. County of Death

HARFORD

5. Social Security Number

220-12-5357

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

8. Date of Birth

If Under 1 Year  
Months Days Hours Min.

9. Birthplace (State or Foreign Country)

Nov. 10, 1917 Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

606 Kilmarnock Trail

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Anthony (unk) Jeppi

18. Mother's Name (First, Middle, Maiden Surname)

Julia (unk) Lamanna

19a. Informant's Name/Relationship (Type, Print)

Margaret T. Vale / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

606 Kilmarnock Trail, Bel Air, Maryland 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

Date

2-4-08

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Steph A. Neugebauer

22. Name and Address of Facility

McComas Funeral Home, P.A.  
1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ALZHEIMERS

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Assisted care

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Steph A. Neugebauer

29c. License number

D 39889

29d. Date signed (Month, Day, Year)

January 30, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALFRED SPANUS 615 W. Macphail Bel Air MD 21014

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

Steph A. Neugebauer

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, Hy.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02584

1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Marie Burnett

2. Date of Death  
Month Day Year  
January 24, 20083. Time of Death  
1900 hrs

4a. Facility Name (if not institution, give street and number)

2 North Smallwood Street Apt. 317

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

065-22-2929

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

11/25/19

9. Birthplace (State or Foreign Country) MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2 North Smallwood Street Apt 317

10f. Zip Code

21223

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Representative

16b. Kind of Business/Industry

Five And Dime Department Store

17. Father's Name (First, Middle, Last)

James Russell

18. Mother's Name (First, Middle, Maiden Surname)

Mary Doull

19a. Informant's Name/Relationship (Type, Print)

Kirklen Gadison -Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15407 Swancreek Dr. Houston TX 77095

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Cem.

Date

1/31/08

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensed

*Shirley K. Jones*

22. Name and Address of Facility

1101 E. North Ave Baltimore, MD 21202

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No 3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*David Fowler M.D.*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 25, 2008

30. Name and address of person who completed cause of death (Item 23a)

David Fowler M.D. Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

*David Fowler M.D.*Physician/  
Medical Examiner  
  
Funeral  
Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02585

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |
|---|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Lena L. Clouser   |  | 2. Date of Death<br>Month Day Year<br>February 01 2008  |   | 3. Time of Death<br>02:05 AM   |
|   | 4a. Facility Name (If not institution, give street and number)<br>519 Newfield Road   |  | 4b. City, Town, or Location of Death<br>Glen Burnie   |   | 4c. County of Death<br>Anne Arundel  |
| Funeral<br>Director   | 5. Social Security Number<br>216-18-7182  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>83 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>Aug. 21 1924 | 9. Birthplace (State or Foreign Country)<br>MD   |
|   | Usual Residence of Decedent   |  |   |   |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  | 10b. County<br>Anne Arundel  | 10c. City, Town or Location<br>Glen Burnie  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br>519 Newfield Road   |  | 10f. Zip Code<br>21061  |   | 10g. Citizen of What Country?<br>USA   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+)                                 |   |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Retail Sales   |  | 16b. Kind of Business/Industry<br>Department Stores   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>William E. Thielbahr   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Annie B. Nagel   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Diane L. Koblinsky (daughter)   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>519 Newfield Road, Glen Burnie, MD 21061             |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery   |   | 20c. Location - City or Town, State<br>Feb. 05 2008 Baltimore, Maryland  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  | 22. Name and Address of Facility<br>Stallings Funeral Home, P.A.<br>3111 Mountain Road, Pasadena, MD 21122  |   |  |
|   | 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Chronic Renal Failure<br>Due to (or as a consequence of):<br>b. Coronary Artery Disease<br>Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |   |  |
| Approximate Interval Between Onset and Death<br>34 years<br>8 years   |   |  |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |   |  |   |   |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death<br>5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown   |   |  |   |   |  |
| 23d. Date of delivery<br>Month Day Year   |   |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Coronary Artery Disease   |   |  |   |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |   |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |  |   |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   |  |   |   |  |
| 28a. Date of Injury (Month, Day Year)   |   |  |   |   |  |
| 28b. Time of Injury<br>M  |   |  |   |   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |   |  |
| 28d. Describe how injury occurred   |   |  |   |   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |   |  |
| 29b. Signature and title of certifier<br>William M. Attending Doctor  |   |  |   |   |  |
| 29c. License number<br>D 21654  |   |  |   |   |  |
| 29d. Date signed (Month, Day, Year)<br>02/01/2008   |   |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>C-V. CYRIAC M-D, 8021 RITCHIE HWY, PASADENA, MD 21122   |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 01 2008  |   |  |   |   |  |
| 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |   |   |  |

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

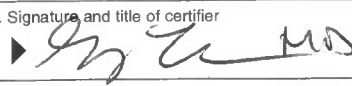
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02586

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |   |  |                                   |  |
|--|--|---|---|--|-----------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Margaret A. Carl</b>  |  | 2. Date of Death<br>Month <b>January</b> Day <b>27</b> Year <b>2008</b>   |   | 3. Time of Death<br><b>12:10 P<sup>M</sup></b>   |                                   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Heartlands Assisted Living</b>  |  | 4b. City, Town, or Location of Death<br><b>Ellicott City</b>  |   | 4c. County of Death<br><b>Howard</b>   |                                   |  |
| 5. Social Security Number<br><b>722-12-3913</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>102</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 19, 1905</b>                   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |                                   |  |
| Usual Residence of Decedent  |  |   |   |  |                                   |  |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Howard</b>   | 10c. City, Town or Location<br><b>Ellicott City</b>   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                                   |  |
| 10e. Street and Number<br><b>3004 N. Ridge Road</b>  |  | 10f. Zip Code<br><b>21043</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |                                   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4or 5+) <b>12</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>   |   | 16b. Kind of Business/Industry<br><b>Railroad</b>  |                                   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Ridgely L. Griffith</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Stumpner</b> |  |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joan E. Cass Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>201 Rolling Brook Way; Catonsville, MD 21228</b>  |   |  |                                   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crestlawn Mem. Gardens</b>   |   | 20c. Location - City or Town, State<br><b>2-1-2008 Marriottsville, Maryland</b>  |                                   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228</b>   |   |  |                                   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Dementia</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |                                   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death<br>9 <input type="checkbox"/> Unknown   |   | 23d. Date of delivery<br>Month Day Year  |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>  |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                                   |  |
| 27. Manner of Death<br>2 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>3 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br><b>M</b>   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   | 28d. Describe how injury occurred |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D50517</b>   |                                   |  |
| 29d. Date signed (Month, Day, Year)<br><b>1/29/08</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Gregory Cendek 1120 N. Rolling RD Balto MD 21228</b>   |   |  |                                   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>  |  | 32. Registrar's Signature<br>  |   |  |                                   |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02587

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kathleen Mary Collins

2. Date of Death

January 29, 2008

3. Time of Death

8:12 P<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Frederick Villa Nursing Home

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

216-14-8700

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

8. Date of Birth

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

9. Birthplace (State or Foreign Country)

Sept. 16, 1923 Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

103 S. Hilltop Road

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Edward T. McNaney

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Fluskey

19a. Informant's Name/Relationship (Type. Print) Husband

James Patrick Collins, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 S. Hilltop Road; Catonsville, MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crest Lawn Mem. Garden 2/2/2008

Date

20c. Location - City or Town, State

Marriottsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Sterling Ashton Schwab Witzke

Funeral Home of Catonsville, Inc.

1630 Edmondson Avenue; Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DVT - Leg  
Dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R Fernandez Attending MD

29c. License number

D50303

29d. Date signed (Month, Day, Year)

1/30/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R FERNANDEZ MD 516 N ROLLING RD STE 205 Catonsville

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02588

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA VIRGINIA CHENOWITH

2. Date of Death

Month Day Year  
JANUARY 30, 2008

3. Time of Death

5:25 P.M.

4a. Facility Name (If not institution, give street and number)

STELLA MARIS HOSPICE

4b. City, Town, or Location of Death

TIMONIUM

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

214-20-0382

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
10/6/1921

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

PARKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9215 SMITH AVENUE

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12TH GRADE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

PETER CASPER HEIN

18. Mother's Name (First, Middle, Maiden Surname)

EDNA HAGEDORN

19a. Informant's Name/Relationship (Type, Print)

LINDA WILSON/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 NORTHAMPTON ROAD TIMONIUM, MD 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DRUID RIDGE CEMETERY

Date

2/4/2008

20c. Location - City or Town, State

PIKESVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

1/31/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 Dulany Valley Rd.

TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

State  
RegistrarJANUARY 30, 2008 5:25 PM  
Baltimore, Maryland 21215-0036ANNA VIRGINIA CHENOWITH  
Division of Vital Records, P.O. Box 68760,To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02589

1- For State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical Examiner

|  |  |  |  |                              |
|--|--|--|--|------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br>James Cook |  | 2. Date of Death<br>Month Day Year<br>January 22, 2008 |  | 3. Time of Death<br>0535 hrs |
|--|--|--|--|------------------------------|

|   |  |  |
|---|--|--|
| 4a. Facility Name (if not institution, give street and number)<br>Prince George's Hospital Center | 4b. City, Town, or Location of Death<br>Cheverly | 4c. County of Death<br>Prince George's |
|---|--|--|

|  |  |   |   |   |
|--|--|---|---|---|
| 5. Social Security Number<br>423-86-6668 | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>50 Yrs. | 8. Date of Birth (MM/DD/YYYY)<br>11/24/1957 | 9. Birthplace (State or Foreign Country)<br>Alabama |
|--|--|---|---|---|

|                             |                     |   |  |
|-----------------------------|---------------------|---|--|
| Usual Residence of Decedent |                     | 10c. City, Town or Location<br>Mableton | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 10a. State<br>Georgia       | 10b. County<br>Cobb |   |  |

|   |                        |                                      |
|---|------------------------|--------------------------------------|
| 10e. Street and Number<br>435 Pine Valley Rd. | 10f. Zip Code<br>30126 | 10g. Citizen of What Country?<br>USA |
|---|------------------------|--------------------------------------|

|  |   |   |  |
|--|---|---|--|
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |
|--|---|---|--|

|   |  |  |
|---|--|--|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>3 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Nurse | 16b. Kind of Business/Industry<br>Nursing Home |
|---|--|--|

|  |  |
|--|--|
| 17. Father's Name (First, Middle, Last)<br>John Cook | 18. Mother's Name (First, Middle, Maiden Surname)<br>Addie Johnson |
|--|--|

|   |   |
|---|---|
| 19a. Informant's Name/Relationship (Type, Print)<br>Lisa M. Cook - wife | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>435 Pine Valley Rd., Mableton, Georgia 30126 |
|---|---|

|  |  |                       |   |
|--|--|-----------------------|---|
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory | Date<br>Jan. 27, 2008 | 20c. Location - City or Town, State<br>Alexandria, Virginia |
|--|--|-----------------------|---|

|  |   |
|--|---|
| 21. Signature of Funeral Service Licensee<br>MFGH 001234 | 22. Name and Address of Facility<br>Fleck Funeral Home, INC.<br>7601 Sandy Spring Rd., Laurel, Maryland 20707 |
|--|---|

|  |  |
|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Atherosclerotic cardiovascular disease complicating neck fracture<br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death |
|--|--|

|   |  |
|---|--|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of): |  |
|---|--|

|  |   |
|--|---|
| c. Due to (or as a consequence of):          |   |
| d. Due to (or as a consequence of):          |   |
| <input checked="" type="checkbox"/> UNPENDED | <input checked="" type="checkbox"/> AMENDED 28f, per ME, g877, 3/4/08 TT<br>#25a, 27, 28a-f, per ME, g876, 2/25/08 TT |

|  |   |   |
|--|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|--|--|

|   |  |
|---|--|
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|---|--|

|   |  |
|---|--|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other: |
|---|--|

|   |  |                                 |   |   |
|---|--|---------------------------------|---|---|
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year)<br>June 8, 2007 | 28b. Time of Injury<br>10:14 pm | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred<br>pedestrian hit by vehicle(s) |
|---|--|---------------------------------|---|---|

|  |  |
|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Roadway | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Fontaine Road, GA Savannah, GA |
|--|--|

|   |  |                                 |   |
|---|--|---------------------------------|---|
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | 29b. Signature and title of certifier<br>Ana Rubio | 29c. License number<br>O.C.M.E. | 29d. Date signed (Month, Day, Year)<br>January 24, 2008 |
|---|--|---------------------------------|---|

|   |
|---|
| 30. Name and address of person who completed cause of death (Item 23a)<br>Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 |
|---|

|  |  |
|--|--|
| 31. Date filed (Month, Day, Year)<br>FEB 01 2008 | 32. Registrar's Signature<br>[Signature] |
|--|--|

State  
Registrar

Baltimore, MD 21215-0036  
 permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
Medical Examiner

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02590

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Luvisie Craig

2. Date of Death

January 14, 2008

3. Time of Death

12:45 A M

4a. Facility Name (If not institution, give street and number)

Laurel regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

UNK

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 18, 1923

9. Birthplace (State or Foreign Country)

Mississippi

Usual Residence of Decedent

10a. State

California

10b. County

Los Angeles

10c. City, Town or Location

Canoga Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

22319 Runnymede Street

10f. Zip Code

91303

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Clothing

17. Father's Name (First, Middle, Last)

Joseph Davis

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Macadori

19a. Informant's Name/Relationship (Type, Print)

Marvin H. Craig- son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22319 Runnymede Street, Canoga Park, California 91303

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

Jan. 16, 2008

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

MDgm M01234

22. Name and Address of Facility

Fleck Funeral Home, INC.  
7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Anoxia Encephalopathy

Due to (or as a consequence of):

b. Multi Organ Failure

Due to (or as a consequence of):

c. Sepsis

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

Shahab Bavani

29c. License number

D64874

29d. Date signed (Month, Day, Year)

January 14, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shahab Bavani, MD, 10724 Little Patuxent Parkway, Ste 200, Columbia, Maryland 21044

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760, 48

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02591

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thelma M. Cole

2. Date of Death

Month Day Year  
JANUARY 26, 2008 09:05 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

236-48-6520

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

May 22, 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

509 E. Joppa Road

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

bus driver

16b. Kind of Business/Industry

balto county schools

17. Father's Name (First, Middle, Last)

Thomas Lee Woods

18. Mother's Name (First, Middle, Maiden Surname)

Anna Bessie Alexander

19a. Informant's Name/Relationship (Type, Print)

Timothy Cole/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4151 Madonna Road Jarrettsville, MD 21084

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. SEPSIS

Due to (or as a consequence of):

b. ABDOMINAL WOUND INFECTION

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RESPIRATORY DISTRESS

DIABETES MELLITUS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D37254

29d. Date signed (Month, Day, Year)

1/26/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOON POH LIM, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02592

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>MARY LOUISE CUTHBERT</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>JANUARY 26, 2008</b>  |  |  |  | 3. Time of Death<br><b>18:23 M</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Harford Memorial Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Havre de Grace</b>  |  |  |  | 4c. County of Death<br><b>Harford</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>219-30-1265</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 8, 1935</b>                   |  | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>  |  |
|   | Usual Residence of Decedent   |  |   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Harford</b>  |  | 10c. City, Town or Location<br><b>Aberdeen</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 10e. Street and Number<br><b>320 Northeast Road</b>  |  | 10f. Zip Code<br><b>21001</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>      |  |  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Jim (nmn) Manning</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Susan Watson</b>  |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner             | 19a. Informant's Name/Relationship (Type, Print)<br><b>Deborah Williams / Daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1011 Bear Corbitt Road, Bear, DE 19701</b>   |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cokesbury U.M.C. Cem.</b>  |  | Date<br><b>1-30-08</b>   |  | 20c. Location - City or Town, State<br><b>Abingdon, Maryland</b>             |  |  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Steph A. Hargis</b>   |  |   |  | 22. Name and Address of Facility<br><b>McComas Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, Maryland 21009</b>  |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Arteriosclerotic Cardiovascular disease</b><br>Due to (or as a consequence of):<br><b>Cerebrovascular accident</b><br>Due to (or as a consequence of):<br><b>Coronary artery disease</b><br>d. |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |
| To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)                                       |  | 28b. Time of Injury<br><b>M</b>  |  |
|   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><b>J. T. Lee</b>   |  | 29c. License number<br><b>p20661</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>1/28/08</b>                        |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. T. Lee M.P. 669 Revolution St. Havre de Grace MD 2078</b>   |  |   |  |  |  |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02593

1- For  
State  
Registrar

|   |   |  |   |   |  |  |
|---|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Patricia Demarest   |  | 2. Date of Death<br>Month Day Year<br>January 27 2008   |   | 3. Time of Death<br>12:34 P.M.   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br>Baltimore Washington Medical Center   |  | 4b. City, Town, or Location of Death<br>Glen Burnie   |   | 4c. County of Death<br>Anne Arundel  |  |
| Funeral<br>Director   | 5. Social Security Number<br>161-20-4163  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>80 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>Feb. 21 1927 | 9. Birthplace (State or Foreign Country)<br>FL   |  |
|   | Usual Residence of Decedent   |  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  | 10b. County<br>Anne Arundel  | 10c. City, Town or Location<br>Severna Park   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|   | 10e. Street and Number<br>7 Woodbent Drive  |  | 10f. Zip Code<br>21146  |   | 10g. Citizen of What Country?<br>USA   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker   |  |
|   | 16b. Kind of Business/Industry<br>Household   |  | 17. Father's Name (First, Middle, Last)<br>Alexander Demarest   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth Wentz   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Cheryl Bond (daughter)  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7 Woodbent Drive, Severna Park, MD 21146   |   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mummet Cemetery   |   | 20c. Location - City or Town, State<br>Jan. 31 2008 East Berlin, Pennsylvania  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>Stallings Funeral Home, P..<br>3111 Mountain Road, Pasadena, MD 21122   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Chronic obstructive pulmonary disease<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):                                     |  |   |   |  |  |
|   | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>dementia. |   |  |   |   |  |  |
| Physician<br>/Medical<br>Examiner   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  |
|   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   |  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| State<br>Registrar  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>MD   |   | 29c. License number<br>D43977  |  |
|   | 29d. Date signed (Month, Day, Year)<br>January 27 2008  |  | 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)<br>Gwen Doleynski 301 Hospital Drive, Glen Burnie MD 21061.  |   |  |  |
|   | 31. Date filed (Month, Day, Year)<br>FEB 01 2008  |  | 32. Registrar's Signature<br>   |   |  |  |
|   |   |  |   |   |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division or Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02594

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ROBERT (NMN) DAMSGAARD JR.

2. Date of Death  
Month Day Year  
JANUARY 28, 20083. Time of Death  
5:11 A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

GILCHRIST @ GBMC

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

215-46-7531

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

8. Date of Birth (Month, Day, Year)

Aug. 1, 1946

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Forest Hill

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number

713 Walters Mill Road

10f. Zip Code

21050

10g. Citizen of What Country?

USA

11. Marital Status  
1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Pharmaceutical Sales

16b. Kind of Business/Industry

Pharmaceutical Company

17. Father's Name (First, Middle, Last)

Robert (nmn) Damsgaard Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Annalise (nmn) Aardrup

19a. Informant's Name/Relationship (Type, Print)

Ann M. Damsgaard / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

713 Walters Mill Road, Forest Hill, MD 21050

20a. Method of Disposition  
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or place)

Hilltop Service Corp. 2-4-08

Date

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

Steph A. Neerph

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. prostate cancer  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
years

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Hospice

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dr. [Signature]

29c. License number

D 58303

29d. Date signed (Month, Day, Year)

January 28 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARON J. CHARLES MD 6701 N. Charles ST TOWSON MD 21204

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760, 1811

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02595

1- For  
State  
Registrar

|  |  |   |   |  |  |  |  |  |  |  |
|--|--|---|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Connie Gail Dew</b>   |   |   |  | 2. Date of Death<br>Month <b>January</b> Day <b>29</b> Year <b>2008</b>  |  |  |  | 3. Time of Death<br><b>7:05 A M</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Upper Chesapeake Medical Center</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Bel Air</b>   |  |  |  | 4c. County of Death<br><b>Harford</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-58-4415</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 4, 1950</b> |  | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>                                |  |
|  | Usual Residence of Decedent  |   |   |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Street</b>   |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>1019 Heaps Road</b>   |   |   |  | 10f. Zip Code<br><b>21154</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                |  |  |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Director of Purchasing</b>   |  |  | 16b. Kind of Business/Industry<br><b>Dixie Printing</b>  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Paul H. Dew</b>  |   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel Ashe</b>               |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Martha Deems-sister</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1019 Heaps Road-Street, Maryland 21154</b>   |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>EVANS FUNERAL CHAPEL AND CREMATION SERVICES BELAIR</b>  |  | Date<br><b>1/31/08</b>                                     |  | 20c. Location - City or Town, State<br><b>Forest Hill, Maryland</b>                              |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>EVANS FUNERAL CHAPEL AND CREMATION SERVICES 3 Newport Drive Forest Hill, Maryland 21050</b>   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Pancytopenia</b><br>Due to (or as a consequence of):<br>b. <b>Intractable Pain 2° to metastatic breast cancer</b><br>Due to (or as a consequence of):<br>c. <b>Brain metastasis</b><br>Due to (or as a consequence of):<br>d. <b>Breast Cancer</b> |   |   |  |  |  |  |  |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year                    |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>        |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Kamal Bangoria M.D.</b>   |   | 29c. License number<br><b>D0065647</b> |  | 29d. Date signed (Month, Day, Year)<br><b>1/29/08</b>                                |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>KAMAL G. BANGORIA 500 UPPER CHESAPEAKE DRIVE, BELAIR, MD-21014</b>  |  |   |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>  |  | 32. Registrar's Signature<br>   |   |  |  |  |  |  |  |  |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02596

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hattie Drakeford

2. Date of Death

January 28, 2008

3. Time of Death

11:00 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Bradford Oaks Nursing Home

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

5. Social Security Number

239-34-5681

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

3-28-1923

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Prince Georges10c. City, Town or Location  
Camp Springs

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6711 Coolridge Rd.

10f. Zip Code

20748

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8College (1-4or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Lemuel Clyburn

18. Mother's Name (First, Middle, Maiden Surname)

Estelle Blakeney

19a. Informant's Name/Relationship (Type, Print)

Patsy McIlwain (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6711 Coolridge Rd. Camp Springs, MD 20748

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pleasant Hill Church

Date

2-2-2008

20c. Location - City or Town, State

Heath Springs, SC

21. Signature of Funeral Service Provider

Roy L. Mason m00963

22. Name and Address of Facility

Lee Funeral Home, Inc.  
6633 Old Alexandria Ferry Rd. Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Arteriosclerotic cardiovascular disease*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D1941

29d. Date signed (Month, Day, Year)

1/28/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fayth M Ryan MD 11701 Livingston Rd #103 Ft. Washington MD 20744

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760, 2

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

H

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

Amend Items 29d, 30 per dr. 687602/01/08dhb

Reg. No. 2008 02597

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Durham Jr

2. Date of Death

January 18, 2008

3. Time of Death

3:20 PM M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Charlotte Hall Veterans Home

4b. City, Town, or Location of Death

Charlotte Hall

4c. County of Death

St. Mary's

5. Social Security Number

215-07-9437

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
May 13, 1921

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3417 Springdale Avenue

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: '43-4613. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

engineer

16b. Kind of Business/Industry

electronics

17. Father's Name (First, Middle, Last)

James Durham

18. Mother's Name (First, Middle, Maiden Surname)

Louise Armstrong

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Durham/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3417 Springdale Avenue Baltimore, MD 21216

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION, DIABETES MELLITUS  
HYPOTHYROIDISM

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Ronald S. Wade

29c. License number

D0056752

29d. Date signed (Month, Day, Year)

January 31, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAZMIN ESPRANI, MD Charlotte Hall Veterans Home

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02598

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Donald Walton

Dickson

2. Date of Death  
Month Day Year

January 29 2008

3. Time of Death

1:48 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

5. Social Security Number

276-22-5169

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Aug. 24, 1927

9. Birthplace (State or Foreign  
Country)

Ohio

Usual Residence of Decedent

10a. State  
Maryland  
10b. County  
Prince George's

10c. City, Town or Location

Fort Washington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12308 Dendron Place

10f. Zip Code

20744

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No 1946-  
If Yes, Give  
Year or Dates: 198513. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12thCollege (1-4or 5+)  
8+16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

COL. USAF Ret.

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Edgar N. Dickson

18. Mother's Name (First, Middle, Maiden Surname)

Cora B. Weber

19a. Informant's Name/Relationship (Type, Print)

Nancy Dickson (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12308 Dendron Place Ft. Washington, Maryland 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)March 21,  
Arlington National Cem. 2008

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Home Licensee

MOI 464

22. Name and Address of Facility

Lee Funeral Home, Inc.  
6633 Old Alexandria Ferry Road Clinton, MD 2073523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiac arrhythmia

Approximate  
Interval Between  
Onset and Death

minutes

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Bilateral Pulmonary Pneumonia (MRSA)

week.

c. COPD

years

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD, Chronic lymphocytic leukemia,  
Diabetes mellitus, myocardial infarction,  
shingles

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. Smolenski

29c. License number

D0061614

29d. Date signed (Month, Day, Year)

January 29<sup>th</sup>, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ravinder Singhani, MD 11350 Pembroke Sq, Suite 304 Waldorf, MD 20603

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

James B. Smith

ORIGINAL

Dickson, Donald  
Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, F

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

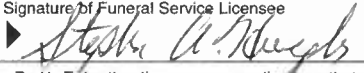


Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 02599

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

|   |   |  |   |  |   |  |   |  |
|---|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>RAYMOND (NMN) DAVIS SR.</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>JANUARY 24, 2008</b>   |  | 3. Time of Death<br><b>3:40 P M</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>STELLA MARIS HOSPICE</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>TIMONIUM</b>   |  | 4c. County of Death<br><b>HARFORD</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>120-34-6617</b>   |  | 6. Sex<br><b>1 M 2 F</b>  |  | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 29, 1946</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>New York</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Edgewood</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><b>1 Yes 2 No</b>  |  | 10e. Street and Number<br><b>1435 St. Christopher Ct.</b>   |  | 10f. Zip Code<br><b>21040</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|   | 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No Specify:</b>      |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: Black</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Manager</b>                                   |  | 16b. Kind of Business/Industry<br><b>Can Manufacturer</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>James Robert Davis</b>  |  |
|   | 17. Mother's Name (First, Middle, Maiden Surname)<br><b>Mattie Lee King</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lovett Davis / Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>25 Perry Oak Place, Baltimore, MD 21236</b> |  | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>             |  |
| Physician<br>/Medical<br>Examiner             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp</b>   |  | 20c. Location - City or Town, State<br><b>Towson, Maryland</b>  |  | 21. Signature of Funeral Service Licensee<br>                  |  | 22. Name and Address of Facility<br><b>McComas Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, Maryland 21009</b> |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>LUNG CANCER</b> |  | 23b. Was decedent pregnant in the past 12 months?<br><b>1 Yes 2 No 9 Unknown</b>  |  | 23c. If yes, outcome of pregnancy<br><b>1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)</b>        |  | 23d. Date of delivery<br>Month Day Year   |  |
| To Be Completed by Physician/Medical Examiner | 23e. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>  |  | 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>  |  | 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |  |
|   | 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify) Hospice</b>  |  | 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>                       |  | 28a. Date of Injury (Month, Day Year)   |  |
| To Be Completed by Physician/Medical Examiner | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><b>1 Yes 2 No</b>   |  | 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)                                  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><b>1 Medical Examiner</b>  |  | 29b. Signature and title of certifier<br>                    |  | 29c. License number<br><b>D43725</b>  |  |
| State Registrar                               | 29d. Date signed (Month, Day, Year)<br><b>1128208</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>TARIQ MAHMOOD, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM MD 21093</b> |  | 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>   |  | 32. Registrar's Signature<br>        |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02600

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ellarose Elizabeth Emmel

2. Date of Death  
Month Day Year  
January 30, 20083. Time of Death  
1:26 P<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

2611 Old Joppa Road

4b. City, Town, or Location of Death

Joppa

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

212-50-7181

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

8. Date of Birth (Month, Day, Year)

Mar. 15, 1917 Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Joppa

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2611 Old Joppa Road

10f. Zip Code

21085

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Jacob H. Hohl

18. Mother's Name (First, Middle, Maiden Surname)

Anna (MNN) Brandt

19a. Informant's Name/Relationship (Type, Print)

Kim A. Williams / Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7729 Buck Hill Road, Kingsville, MD 21087

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Franklinville Presbyterian

Date

2-2-08

20c. Location - City or Town, State

Bradshaw, Maryland

21. Signature of Funeral Service Licensee

*Charles W. Wynn*

22. Name and Address of Facility

McComas Funeral Home, P.A.  
1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Renal Failure

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
2 months

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*P. D. Williams*

29c. License number

D29227

29d. Date signed (Month, Day, Year)

1/31/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. L. Williams - Phila. Co. Del. Air. MD 21014

PATRICIA DUBOISKI

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

*James H. Smith*

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760, 430

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

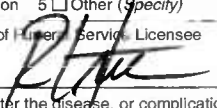
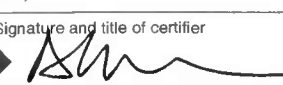
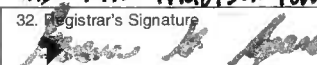
State of Maryland / Department of Health and Mental Hygiene

2008 02601

## Certificate of Death

Reg. No.

1- For State Registrar

|  |   |  |   |  |   |  |
|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Saveria M. Fisher</b>  |  | 2. Date of Death<br>Month Day Year<br><b>January 28, 2008</b>   |  | 3. Time of Death<br><b>11:00P M</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Glen Burnie Health &amp; Rehabilitation</b>  |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>  |  | 4c. County of Death<br><b>Anne Arundel</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-12-8399</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 16, 1922</b>                          | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |
|  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Glen Burnie</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>7355 E. Furnace Branch Road</b>  |  | 10f. Zip Code<br><b>21060</b>   |  |
|  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
|  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk Typist</b>  |  | 16b. Kind of Business/Industry<br><b>Accounting</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Antonio Miceli</b>  |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Brigandi</b>   |  | 19a. Informant's Name/Relationship (Type, Print) <b>Husband</b><br><b>Mr. Martin R. Fisher Sr./</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7548 Old Telegraph Road Hanover, MD 21076</b>   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial</b>   |  | 20c. Location - City or Town, State<br><b>Jan 31, Elkrige, MD</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Singleton Funeral &amp; Cremation Services 1 2nd Avenue Glen Burnie, MD 21061</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Metabolic Encephalopathy</b><br>Due to (or as a consequence of):<br>b. <b>Hip fracture</b><br>Due to (or as a consequence of):<br>c. <b>Osteoporosis</b><br>Due to (or as a consequence of):<br>d. <b>Urinary tract infection</b> |  |
|  | 23b. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 23c. Date of delivery<br>Month Day Year   |  | 23d. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |
|  | 23e. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23f. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 23g. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  | 24. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 25. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 26. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |
| 27. Date of Injury (Month, Day Year)<br><b>Jan 28, 2008</b>  |   | 27b. Time of Injury<br><b>M</b>  |   | 27c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 27d. Describe how injury occurred  |   | 27e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 27f. Location (Street and Number or Rural Route Number, City or Town, State)         |   |  |
| 28a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 28b. Signature and title of certifier<br> <b>Physician</b>                            |   | 28c. License number<br><b>D56950</b>   |   |  |
| 28d. Date signed (Month, Day, Year)<br><b>January 29, 2008</b>   |   | 29. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Nnaemeka Agajelu md 1411 Madison Park Drive Suite 1b Glen Burnie MD 21061</b> |   | 30. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>                              |   |  |
| 31. Registrar's Signature<br>   |   | 32. State Registrar  |   |  |   |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02602

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Faith A. Fahrenstock

2. Date of Death

January 29, 2008 21:50 M

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Upper Chesapeake Medical Center

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford County

5. Social Security Number

218-48-2095

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60

8. Date of Birth

May 1, 1947

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford Co.

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1509 Honeysuckle Drive

10f. Zip Code

21014

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Department of Veterans Affairs

17. Father's Name (First, Middle, Last)

Henry A. Legge

18. Mother's Name (First, Middle, Maiden Surname)

Esther Hoffman

19a. Informant's Name/Relationship (Type, Print)

Mr. Richard Fahnstock

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1509 Honeysuckle Drive Bel Air, MD

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel

Date

1/31 2008

20c. Location - City or Town, State

Forest Hill, MD.

21. Signature of Funeral Service Licensee

Leann J. Lenn

22. Name and Address of Facility

Evans Funeral Chapel & Cremation Services  
3 Newport Drive, Forest Hill, MD 21050

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Bacteremia

b. Due to (or as a consequence of):

Endocarditis

c. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

19 days

19 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease

Pulmonary Septic Emboli

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Marco Zamora

29c. License number

D40819

29d. Date signed (Month, Day, Year)

January 29, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marco Zamora MD 500 Upper Chesapeake Drive, Bel Air MD 21014

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

ORIGINAL

1/29/08 2150  
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any time.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit record.

Fahnstock, Faith M800253360  
Division of Vital Records, P.O. Box 68760, 48



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Amend Item 23a per dr., 876, 02/01/08

Certificate of Death

Reg. No. 2008 02603

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |                                |  |  |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>QUINCY FORD</b>  |  |   |  | 2. Date of Death<br>Month <b>JANUARY</b> Day <b>20</b> Year <b>2008</b>  |                                | 3. Time of Death<br><b>3:39 PM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>DOCTOR'S COMMUNITY HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>LANHAM</b>  |                                | 4c. County of Death<br><b>PRINCE GEORGES</b>   |  |
| 5. Social Security Number<br><b>559 96 1391</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>SEP. 15, 1955</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>CALIFORNIA</b>   |  |   |  |  |                                |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>PRINCE GEORGES</b>  |  | 10c. City, Town or Location<br><b>CAPITOL HEIGHTS</b>  |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>6805 MOUNTAIN LAKE PLACE</b>   |  |   |  | 10f. Zip Code<br><b>20743</b>  |                                | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1977-83</b>                                  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input type="checkbox"/> <b>2YRS.</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MERCHANDISER</b>   |                                | 16b. Kind of Business/Industry<br><b>PEPSI CO.</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>ROYCE FORD</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ADA SCOTT</b>  |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>HENRIETTA FORD / WIFE</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6805 MOUNTAIN LAKE PL. CAPITOL HEIGHTS, MD 20743</b>                                     |                                |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>METROPOLITAN CREMATORY</b>   |  | Date<br><b>01/29/08</b>  |                                | 20c. Location - City or Town, State<br><b>ALEXANDRIA, VA</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>D. GRAY 1523</b>  |  |   |  | 22. Name and Address of Facility<br><b>MARSHALL'S FUNERAL HOME OF MARYLAND, INC.<br/>4308 SUITLAND ROAD SUITLAND, MD 20746</b>   |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Septic shock Pneumonitis</b>  |  |   |  |  |                                |  | Approximate Interval Between Onset and Death |
| 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |  |  |                                |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown |  | 3 <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)  |                                | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |                                | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |                                | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 28d. Describe how injury occurred   |  |   |  |  |                                | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |                                | 29b. Signature and title of certifier<br><b>[Signature]</b>  |  |
| 29c. License number<br><b>D45660</b>  |  |   |  |  |                                | 29d. Date signed (Month, Day, Year)<br><b>1-23-08</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>143 GC. CALICANT for [Signature] 124 BOLLIE MD 20711</b>   |  |   |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 29 2008</b>   |  |   |  |  |                                | 32. Registrar's Signature<br><b>[Signature]</b>  |  |

Ford, Quincy

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 445

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02604

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>James Edward Freeman, III</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>January 28, 2008</b>  |  | 3. Time of Death<br><b>8:50 P M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Charlestown Care Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Catonsville</b>   |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| 5. Social Security Number<br><b>705-10-8604</b>   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>June 5, 1915</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Catonsville</b>  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>717 Maiden Choice Lane #325</b>  |  |   |  | 10f. Zip Code<br><b>21228</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1941-42</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>2</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Business Owner</b>   |  | 16b. Kind of Business/Industry<br><b>Retail Stationers</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>James Edward Freeman, Jr.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nellie Gordon Hickman</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Nancy Pluhar Daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>818 Lancaster Drive; Bel Air, MD 21014</b>   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley</b>   |  | Date<br><b>2-1-2008</b>  |  | 20c. Location - City or Town, State<br><b>Timonium, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Sterling Ashton Schwab Witzke<br/>Funeral Home of Catonsville, Inc.<br/>1630 Edmondson Avenue; Catonsville, MD 21228</b>                                  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Stroke</b><br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D47447</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>January 28, 2008</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Andy Green 717 Maiden Choice Lane Catonsville MD</b>   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>   |  |   |  | 32. Registrar's Signature<br>  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital (or Attending Physician): The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02605

1- For State Registrar

Physician  
/Medical  
Examiner

Decedent's Name (First, Middle, Last)

Pearl Green

2. Date of Death  
Month Day Year

01 28 08 4:15AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

7110 Rolling Bend Ct.

4b. City, Town, or Location of Death

Windsor Mill

4c. County of Death

Baltimore

5. Social Security Number

215-24-2147

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

12/12/1925

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Windsor Mill

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7110 Rolling Bend Court

10f. Zip Code

21244

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

Earl Harris

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Middleton

19a. Informant's Name/Relationship (Type, Print)

Bernadette Coles/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17 Braided Whip Ct. Gwynn Oak, MD 21244

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Barrison Forest

Date

2/5/08

20c. Location - City or Town, State

OWINGS MILLS, MD

21. Signature of Funeral Service Licensee

James S. Small M01801

22. Name and Address of Facility

Vaughn C. Greene Funeral Home 8728 Liberty Rd. Randallstown, MD 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic carcinoma lung

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Breast Carcinoma

Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Asher M. Mitter M.D.

29c. License number

D45783

29d. Date signed (Month, Day, Year)

1.29.08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASHA R. MITTAR 7001 Johnny Cake Road Suite 200

BALTIMORE MD 21244

31. Date filed (Month, Day, Year)

1 FEB 01 2008

32. Registrar's Signature

John A. Smith

State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No.

2008 02606

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy C. Gasque

2. Date of Death

January 26, 2008

3. Time of Death

5:50 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Nursing Center

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

216-16-4171

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

8. Date of Birth

April 11, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1016 Veirs Mill Road

10f. Zip Code

20851

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cafeteria Worker

16b. Kind of Business/Industry

Montgomery County

Public Schools

17. Father's Name (First, Middle, Last)

Roy Crown

18. Mother's Name (First, Middle, Maiden Surname)

Faye Mills

19a. Informant's Name/Relationship (Type, Print)

Dennis W. Gasque / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1016 Veirs Mill Rd., Rockville, Maryland 20851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Date

Feb. 1, 2008

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

M00896

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.

300 W. Montgomery Ave., Rockville, MD 20850-2805

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. stroke

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. pneumonia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 month

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0065915

29d. Date signed (Month, Day, Year)

1-28-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chuanbo Zhang, 65-225 Shady Grove Rd, E208, Rockville, MD

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760, 448

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02607

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert General

2. Date of Death  
Month Day Year

January 24 2008

3. Time of Death

00:05 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

UNIVERSITY SPECIALTY HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

577-52-4887

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

8. Date of Birth

Oct 2, 1937

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

201 58th Street NE #34

10f. Zip Code

20019

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
7College (1-4or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

sales

16b. Kind of Business/Industry

automotive

17. Father's Name (First, Middle, Last)

Robert General Sr

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Newkirk

19a. Informant's Name/Relationship (Type, Print)

Bertha General/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 30045 Washington, DC 20030

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. UREMIA  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

ONE MONTH

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RESPIRATORY FAILURE  
CHRONIC KIDNEY DISEASE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) CHRONIC

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D0061765 JANUARY 28<sup>th</sup> 2008  
21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EUGENE QUAINO W 3355 WILKENS AVE #307 BALTIMORE MD

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

State  
RegistrarDivision or Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0036To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02608

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frances Solome Gehret

2. Date of Death

January 17, 2008

3. Time of Death

4:45 AM

4a. Facility Name (If not institution, give street and number)

1836 Emily Drive

4b. City, Town, or Location of Death

Edgewood

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

162-09-8412

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug 13, 1913

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1836 Emily Drive

10f. Zip Code

21040

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

John Sundakas

18. Mother's Name (First, Middle, Maiden Surname)

Cassie Dzindeleski

19a. Informant's Name/Relationship (Type, Print)

Nancy Ledford/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1836 Emily Drive Edgewood, MD 21040

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Donald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Donald S. Wade, MD

29c. License number

D50040

29d. Date signed (Month, Day, Year)

01-23-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1308 Business Center Way #102, Edgewood, MD 21040

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

John S. Wade

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02610

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Lucille Godlewski

2. Date of Death

January 28, 2008

3. Time of Death

4:00 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Calvert Manor Health Care Center

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

5. Social Security Number

512-22-2817

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 1, 1926

9. Birthplace (State or Foreign Country)

Kansas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Colora

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

76 Curtis Lane

10f. Zip Code

21917

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Purchasing Clerk

16b. Kind of Business/Industry

Welding Manufacturer

17. Father's Name (First, Middle, Last)

Alick (nmn) Falconbridge

18. Mother's Name (First, Middle, Maiden Surname)

Anna Lee Bishop

19a. Informant's Name/Relationship (Type, Print)

Shirley L. Reichenbach/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

76 Curtis Lane, Colora, MD 21917

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Holly Hill Mem. Park

Date

1-31-08

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

B. M. V. M.

22. Name and Address of Facility

McComas Funeral Home, P.A.  
1317 Cokesbury Rd., Abingdon, Maryland 2100923a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Coronary artery disease

b. Due to (or as a consequence of):

chronic obstructive lung disease

c. Due to (or as a consequence of):

Hypertension

d. Due to (or as a consequence of):

Depression

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

B. M. V. M.

29c. License number

046412

29d. Date signed (Month, Day, Year)

1/29/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. Sup. Gm 319 S. Union Ave HPC 21078

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

B. M. V. M.

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760, 10

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02611

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CYNTHIA GODDARD

2. Date of Death

January 23 2008

3. Time of Death

9:00 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Assisted Living WOLL

4b. City, Town, or Location of Death

Millersville

4c. County of Death

Anne Arundel

5. Social Security Number

013-12-4044

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

8. Date of Birth (Month, Day, Year)

Oct. 6, 1921

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Millersville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

271 West Pasadena Road

10f. Zip Code

21108

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Othello Peabody Davis

18. Mother's Name (First, Middle, Maiden Surname)

Alice Elizabeth Riney

19a. Informant's Name/Relationship (Type, Print)

William Leonard Goddard Jr / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20 West Pines Drive, Montgomery, TX 77356

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Meorial Grdn 1-26-08

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

DEMENTIA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

ASSISTED

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

LIVAB

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D4636C

29d. Date signed (Month, Day, Year)

January 24, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL A. AMERSON 8601 VETERANS HIGHWAY MILLERSVILLE MD 21108

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 448

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2008 02612

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DELLA ROSE GREENE

2. Date of Death

JANUARY 25, 2008

3. Time of Death

9:35 A M

4a. Facility Name (If not institution, give street and number)

FOREST HILL HEALTH &amp; REHAB CENTER

4b. City, Town, or Location of Death

FOREST HILL

4c. County of Death

HARFORD

Funeral  
Director

5. Social Security Number

215-32-1627

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Mar. 28, 1913

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Forest Hill

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2202 Byton Ct.

10f. Zip Code

21050

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Monroe Younce

18. Mother's Name (First, Middle, Maiden Surname)

Lester Flora Greene

19a. Informant's Name/Relationship (Type. Print)

Sharon G. Walls / Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2202 Byton Ct., Forest Hill, MD 21050

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Grove Bap. Ch. Cem

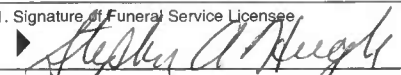
Date

1-28-08

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

McComas Funeral Home, P.A.  
1317 Cokesbury Rd., Abingdon, MD 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *aspiration pneumonia*  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

032279

29d. Date signed (Month, Day, Year)

January 25, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID DUNN -- 615 W. MACPHAIL ROAD - BEL AIR, MD. 21014

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, City

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02613

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

OMA JEANNE HOYT

2. Date of Death

01 30 2008

3. Time of Death

12:10 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

7670 Pine Knob Road

4b. City, Town, or Location of Death

Pasadena

4c. County of Death

Anne Arundel

5. Social Security Number

245-36-6827

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 14 1928

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7670 Pine Knob Road

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cosmetician

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Harley Rhodes

18. Mother's Name (First, Middle, Maiden Surname)

Edith Newman

19a. Informant's Name/Relationship (Type, Print)

Jeanne Rivera (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7670 Pine Knob Road, Pasadena, MD 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Cemetery

Date

Feb. 05 2008

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stallings Funeral Home, P.A.  
3111 Mountain Road, Pasadena, MD 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Breast Carcinoma

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (the disease or condition that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier  
Kathleen Rahn Hume  
29c. License number  
D36146  
29d. Date signed (Month, Day, Year)  
2-1-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KATHERINE H Rahn Hume, Univ of MD Cancer Ctr, 225 Broad St

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

Kathleen Rahn Hume

State  
Registrar

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02614

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alfred William Hogan

2. Date of Death

January 31, 2008

3. Time of Death

7:00 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

6828 Harewood Park Drive

4b. City, Town, or Location of Death

Middle River

4c. County of Death

Baltimore

5. Social Security Number

213-01-2986

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

07/14/1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6828 Harewood Park Drive

10f. Zip Code

21220

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

8

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Steam Fitting

17. Father's Name (First, Middle, Last)

William Patrick Hogan

18. Mother's Name (First, Middle, Maiden Surname)

Lena Marie Hensler

19a. Informant's Name/Relationship (Type, Print)

Joni Bates (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

439 Spry Island Road, Joppa, Maryland 21085

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation - 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

Holly Hill Mem. Gard. 02/02/2008

Date

02/02/2008

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home, P.A.

1407 Old Eastern Avenue, Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. DIABETES MELITUS - TYPE II

Due to (or as a consequence of):

b. HYPERTENSION

Due to (or as a consequence of):

c. HYPER CHOLESTEROL

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1985

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PRIVILEGED VASCULAR DISEASE  
RIGHT BELOW KNEE AMPUTATION

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

FEB 01 2008

10x1

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02615

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Mildred Angela Hinz

2. Date of Death

January 30, 2008

3. Time of Death

2:33 P M

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

215-18-5571

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

8. Date of Birth (Month, Day, Year)

July 8, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Jarrettsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4026 Old Federal Hill Road

10f. Zip Code

21084

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

At Home

17. Father's Name (First, Middle, Last)

Charles Dorsey Berger

18. Mother's Name (First, Middle, Maiden Surname)

Clara Collette LeBaun

19a. Informant's Name/Relationship (Type, Print)

Mr. Joseph W. Hinz, Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4026 Old Federal Hill Road Jarrettsville, Md. 21084

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cemetery 2/2/2008

Date

20c. Location - City or Town, State

Baltimore Maryland

21. Signature of Funeral Service Licensee

Michael D. Doherty

22. Name and Address of Facility

Ruck Tauson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Dementia

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Tariq Mahmood, M.D.

29c. License number

D43725

29d. Date signed (Month, Day, Year)

11/31/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD, M.D.

2300 DULANEY VALLEY ROAD

TIMONIUM MD

21093

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02616

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy A. Hill

2. Date of Death

Jan 29 2008

3. Time of Death

10:40p M

4a. Facility Name (If not institution, give street and number)

37 Clipper Road

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

281-16-4885

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan 11, 1922

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

37 Clipper Road

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Hochschild Kohn

17. Father's Name (First, Middle, Last)

William English

18. Mother's Name (First, Middle, Maiden Surname)

Mary Jane English

19a. Informant's Name/Relationship (Type, Print)

Vernon Hill / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7 Knightsbridge Court Baltimore MD 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery 2/2/08

Date

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

300 Mace Ave. Balto. Md  
Connelly Funeral Home of Essex 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

b. Congestive heart failure

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d. Atrial fibrillation

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

00055171

29d. Date signed (Month, Day, Year)

02/01/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEBASTIAN JOHN 3023 Eastern Avenue Baltimore MD 21224

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2008 02617

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Paula S. Hammen

2. Date of Death

Jan 27 2008

3. Time of Death

8:00p<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

8613 Goldenwood Road

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

218-28-5419

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 29, 1934

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Rosedale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8613 Goldenwood Road

10f. Zip Code

21237

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Robert L. Sadler

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Annen

19a. Informant's Name/Relationship (Type, Print)

Margaret P. Burkett/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12309 Eastern Ave. Balto. MD 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

Date

2/1/08

20c. Location - City or Town, State

Rossville MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

300 Mace Ave. Balto. MD  
Connelly Funeral Home of Essex 21221

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC Non-small Cell Lung Cancer

Approximate Interval Between Onset and Death

18 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D33551

29d. Date signed (Month, Day, Year)

Jan 29, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael AUERBACH, 9110 Philadelphia Rd #314, Baltimore, MD 21227

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02618

1- For  
State  
Registrar

|   |  |  |  |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>James Robert Hooper</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>January 24, 2008</b>   |  | 3. Time of Death<br><b>9:00 P M</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1418 Quaker Church Rd.</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Street</b>   |  | 4c. County of Death<br><b>Harford</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>218-32-8718</b>  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>July 27, 1936</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Street</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>1418 Quaker Church Rd.</b>   |  | 10f. Zip Code<br><b>21154</b>   |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College</b>            |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Senator</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>State Government</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>James Marion Hooper</b>   |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Virginia May Phillips</b>  |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Shirley Hooper / Wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1418 Quaker Church Rd., Street, MD 21154</b>      |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harford Memorial Gdn</b>   |  | 20c. Location - City or Town, State<br><b>1-29-08 Aberdeen, Maryland</b>  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |  |  | 22. Name and Address of Facility<br><b>McComas Funeral Home, P.A.<br/>1317 Cokesbury Rd., Abingdon, MD 21009</b>  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>METASTATIC COLON CANCER</b>  |  |  |  | Approximate Interval Between Onset and Death<br><b>33 MONTHS</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown  |  |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death<br>5 <input type="checkbox"/> Other (specify) <b>9 Unknown</b>   |  |   |  |
|   | 23d. Date of delivery<br>Month Day Year  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |  |  | 28a. Date of Injury (Month, Day Year)   |  |   |  |
|   | 28b. Time of Injury<br><b>M</b>  |  |  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><i>[Signature]</i>  |  |  |  | 29c. License number<br><b>031775</b>  |  |   |  |
|   | 29d. Date signed (Month, Day, Year)<br><b>JANUARY 25 2008</b>  |  |  |  | 30. Name and Address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOAN P. EDWARDS, MD 112 BELAIR ROAD FAUSTON, MARYLAND 21047</b>  |  |   |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>  |  |  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |  |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02619

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Holmes

2. Date of Death

January 29

Day

Year

08

3. Time of Death

8:30 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Fayette Health &amp; Rehab

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

230-14-9801

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

(Month, Day, Year)

8/20/18

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1217 West Fayette ST.

10f. Zip Code

21223

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nursing Assistant

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Elmo Patterson

18. Mother's Name (First, Middle, Maiden Surname)

Marquarite Newmon

19a. Informant's Name/Relationship (Type, Print)

Kathleen Frances-Brooks Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1415 N. Ellwood Ave Baltimore, MD 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD National Mem Park

Date

2/4/08

20c. Location - City or Town, State

Laurel, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

March F/H East

1101 E. North Ave Baltimore, MD 21202

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardio Vascular disease years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c. End stage Renal disease

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D15503

29d. Date signed (Month, Day, Year)

January 29, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMATUN N NAEEM 501 Dolphin Street, Balto, MD 21217

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2008 02620

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph M. Julian

2. Date of Death

JANUARY 30, 2008

3. Time of Death

11:46AM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

218-30-5097

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

July 26, 1934

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baldwin

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13815 Manor Road

10f. Zip Code

21013

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assistant Chief

16b. Kind of Business/Industry

Water Supply

17. Father's Name (First, Middle, Last)

Michale Julian

18. Mother's Name (First, Middle, Maiden Surname)

Viola Testa

19a. Informant's Name/Relationship (Type, Print)

Gloria S. Julian/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13815 Manor Rd. Baldwin MD 21013

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer

Date

Feb 2, 2008

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

Stefanie Rucker

22. Name and Address of Facility

Schimunek Funeral Home Inc.

9705 Belair Rd. Nottingham MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

RESPIRATORY FAILURE

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

PNEUMONIA

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident  
3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Francis Khoo M.D.

29c. License number

D30263

29d. Date signed (Month, Day, Year)

1-30-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

Francis Khoo M.D.

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760, Ky

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02621

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

David W. Jewell, Jr.

2. Date of Death

January 27, 2008

3. Time of Death

5:11 P M

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

230-56-3717

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 24, 1944

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5343 Strathmore Avenue

10f. Zip Code

20895

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Wholesaler

16b. Kind of Business/Industry

Automobile

17. Father's Name (First, Middle, Last)

David W. Jewell, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Katherleen Whitlow

19a. Informant's Name/Relationship (Type, Print)

Brenda Tyler Jewell/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5343 Strathmore Avenue, Kensington, MD 20895

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium

Date

January 30, 2008

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

William R. Pumphrey M01173

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. arteriosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)  
☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy performed?  
☐ Yes ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
☐ Yes ☒ No25. Was case referred to medical examiner?  
☐ Yes ☒ NoHospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Y. Gincherman, M.D.

29c. License number

55410

29d. Date signed (Month, Day, Year)

01/27/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yevgeniy Gincherman, M.D.

Suburban Hospital  
8600 Old Georgetown Rd  
Bethesda, MD 20814

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

State  
Registrar

## State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2008 02622

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Larry Jessup

2. Date of Death

Month Day Year  
January 28, 2008

3. Time of Death

4:30 P<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Manor Care-Bethesda

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

497-46-8093

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
July 22, 1942

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

880 College Parkway #104

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: Vietnam13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Satellite Engineer

16b. Kind of Business/Industry

Public Broadcasting  
Service

17. Father's Name (First, Middle, Last)

Floyd Jessup

18. Mother's Name (First, Middle, Maiden Surname)

Lucile Newport

19a. Informant's Name/Relationship (Type, Print)

Beth Suzanne Jessup/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

880 College Parkway #104, Rockville, MD 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Gate of Heaven  
Cemetery

Date

January  
31, 2008

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

M01346

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave.  
Bethesda, MD 2081423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Failure To Thrive

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Neuromuscular Disorder

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D0057124

29d. Date signed (Month, Day, Year)

January 29, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Truong Bao, M.D., 9715 Medical Center Drive, Rockville, MD 20850

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No. 2008 02623

Physician/  
Medical Examiner

Funeral  
Director

11492

Baltimore, MD 21215-0036

Department of Health and Mental Hygiene  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Sung Hoon Jung</b>  |  | 2. Date of Death<br>Month <b>January</b> Day <b>28</b> Year <b>2008</b>   |  | 3. Time of Death<br><b>1001 hrs</b>  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Howards County General Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>Howard</b>   |  |
| 5. Social Security Number<br><b>None</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>25</b> Yrs.   |  |
|  |  | If Under 1 Year<br>Months Days Hours Min.   |  | 8. Date of Birth (MM/DD/YYYY)<br><b>04-03-1982</b>   |  |
|  |  |   |  | 9. Birthplace (State or Foreign Country)<br><b>Korea</b>   |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Howard</b>  |  | 10c. City, Town or Location<br><b>Ellicott City</b>  |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |  |
| 10e. Street and Number<br><b>4802 Lee Hollow Place</b>   |  | 10f. Zip Code<br><b>21043</b>   |  | 10g. Citizen of What Country?<br><b>Korea</b>  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Asian</b>  |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>4+</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accountant</b>  |  | 16b. Kind of Business/Industry<br><b>Finance</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Moon Chun Jung</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Youngok Ahn</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Youngok Jung - mother</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4802 Lee Hollow Place, Ellicott City, MD 21043</b>  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Mem. Pk.</b>   |  | 20c. Location - City or Town, State<br><b>Elkridge, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Mark M. Brohm</b> M00053   |  | 22. Name and Address of Facility<br><b>Gary L. Kaufman Funeral Home at MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) a. <b>Myocarditis</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. <input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED<br><b>#23a, 27, per ME, g877, 3/5/08 TT</b> |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:          |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury  |  |
|  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Laron Locke</b>  |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>January 29, 2008</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>   |  |   |  |  |  |
| State Registrar<br>31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02624

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

James Jones

2. Date of Death  
Month Day Year

1/29/2008

3. Time of Death

3:30 P<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Bon Secour Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

216-84-4989

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

36

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

11/8/71

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

7 North Smallwood

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th GradeCollege (1-4or 5+)  
NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waiter

16b. Kind of Business/Industry

Resturant

17. Father's Name (First, Middle, Last)

James Lee Huguee

18. Mother's Name (First, Middle, Maiden Surname)

Jennifer Ann Jones

19a. Informant's Name/Relationship (Type, Print)

Jennifer Jones-Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1701 Eutaw Place Apt#916 Baltimore, MD 21217

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Cem

Date

1/31/08

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

March F/H East  
1101 E. North Ave Baltimore, MD 21202

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock

Approximate Interval Between Onset and Death  
Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. AIDS

Due to (or as a consequence of):

c. Acute Hypoxic Respiratory Failure

Due to (or as a consequence of):

d.

Years

Hours

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multiple system organ failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)  
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0066335

29d. Date signed (Month, Day, Year)

JANUARY 29, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGEY R. SHEINFELD

UNIVERSITY OF MARYLAND  
22 SOUTH GREENE ST  
BALTIMORE

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
 Amend #17, 18 & 19a Per INF 6876 2/20/08 JH  
 Registrar Amend #18, per FH, 876, 2/1/08 TT **Certificate of Death** Reg. No. **2008 02625**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Wesley Kerney</b>  |  | 2. Date of Death<br>Month <b>January</b> Day <b>28</b> Year <b>2008</b>   |  | 3. Time of Death<br><b>1430 M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>9857 Good Luck Road #8</b>   |  | 4b. City, Town, or Location of Death<br><b>Lanham</b>   |  | 4c. County of Death<br><b>Prince George's</b>  |  |
| 5. Social Security Number<br><b>306-36-1490</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>May 8 1937</b>   | 9. Birthplace (State or Foreign Country)<br><b>TN</b>  |  |
| Usual Residence of Decedent   |  |   |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince George</b>   |  | 10c. City, Town or Location<br><b>Lanham</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>9857 Good Luck Road Apt 8</b>  |  | 10f. Zip Code<br><b>20706</b>  |  |
| 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Library of Congress</b>   |  | 16b. Kind of Business/Industry<br><b>U.S. Gov. Translator</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Barney Delmar Kerney</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Unknown Leah Penicuff</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Wesley E. Kerney 2nd son</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1141 Double Chestnut Ct. Curtis Bay Md 21226</b> |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory Inc.</b>   |  | 20c. Location - City or Town, State<br><b>1/31/08 Baltimore MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD 21122</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Atherosclerotic Cardiovascular Heart Disease</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  |   |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown   |  |   |  |  |  |
| 23d. Date of delivery<br>Month Day Year   |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>H0055927</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>January 29, 2008</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Salvador Sylvester 309 Hospital Drive, Chevy Maryland</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>   |  | 32. Registrar's Signature<br>   |  |  |  |





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02627

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

|  |  |  |   |  |  |   |   |  |
|--|--|--|---|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>DORETHA KRAUS</b>                                     |  |  | 2. Date of Death<br>Month Day Year<br><b>01-28-08</b>     |  |  | 3. Time of Death<br><b>2:30 A M</b>     |   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>4216 1/2 Silver Spring Road</b> |  |  | 4b. City, Town, or Location of Death<br><b>Perry Hall</b> |  |  | 4c. County of Death<br><b>Baltimore</b> |   |  |
| 5. Social Security Number<br><b>219-10-3282</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>81</b>               |  | 8. Date of Birth (Month, Day, Year)<br><b>10-08-1926</b> |   | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |  |

Funeral  
Director

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Perry Hall</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>4216 1/2 Silver Spring Road</b>  |  |   |  | 10f. Zip Code<br><b>21128</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b>College (1-4or 5+)</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>House Wife</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Lawrence Trentler</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Howard</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Elmer P. Kraus/Husband</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4216 1/2 Silver Spring Rd. Perry Hall MD 21128</b>                                       |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Joseph Cemetery</b>  |  | Date<br><b>02-02-08</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore MD</b>                                     |  |
| 21. Signature of Funeral Service Licensee<br><b>Shimunek Funeral Home Inc.</b>  |  |   |  | 22. Name and Address of Facility<br><b>9705 Belair Rd. Nottingham MD 21236</b>   |  |  |  |

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>DIABETES MELLITUS</b>  |  |   | Approximate Interval Between Onset and Death<br><b>7 YRS</b>  |  |  |
| Due to (or as a consequence of):<br><b>ISCHEMIC COLITIS</b>  |  |   | <b>3 WKS</b>  |  |  |
| Due to (or as a consequence of):   |  |   |   |  |  |
| Due to (or as a consequence of):   |  |   |   |  |  |
| Due to (or as a consequence of):   |  |   |   |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  |
|  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |
| 29b. Signature and title of certifier<br><b>Francis Canmody</b>  |  | 29c. License number<br><b>00001373</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>Jan. 29 2008</b>                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Francis Canmody 7505 Oslen Dr Suite 212 Towson, Md 21204</b>  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>  |  | 32. Registrar's Signature<br><b>John H. [Signature]</b>   |   |  |  |

To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760, [Signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02628

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Faye Spratlin Kloth

2. Date of Death  
Month Day Year

JAN. 29 2008

3. Time of Death

1:37P. M

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

215-28-8899

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs.) last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 5, 1929

9. Birthplace (State or Foreign Country)

Columbia, SC

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore.

10c. City, Town or Location

Glen Arm

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

144 Glen Meadows

10f. Zip Code

21057

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Guy Oneal Spratlin

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth English

19a. Informant's Name/Relationship (Type, Print)

Harry Kloth - Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

144 Glen Meadows, Glen Arm, MD 21057

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

2/2/08

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Kimberly G. Zappotay

22. Name and Address of Facility

Evans Funeral Chapel - Cremation Services - Parkville

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Respiratory Failure

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Bronchopneumonia and Heart Failure

1 week

Due to (or as a consequence of):

Chemotherapy

1 week

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Davis M. Hahn MD

29c. License number

D20396

29d. Date signed (Month, Day, Year)

January 30, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Davis M. Hahn 5601 Loch Raven Blvd Baltimore, Md 21239

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Ky

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02629

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Samuel M. Kirkwood

2. Date of Death

JANUARY 29, 2008 12:29PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

213-01-0061

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 24, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7919 Ruxway Road

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

+4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Accounting

17. Father's Name (First, Middle, Last)

J. Lukey Kirkwood

18. Mother's Name (First, Middle, Maiden Surname)

Lula Anderson

19a. Informant's Name/Relationship (Type. Print)

Mr. David Kirkwood/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1226 Buck Horn Rd. Sykesville, Md. 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem.

Date

2-1-08

20c. Location - City or Town, State

Timonium, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
Ruck Towson Funeral Home, Inc.  
1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. INTRAVENTRICULAR HEMORRHAGE

Due to (or as a consequence of):

b. HEAD TRAUMA FROM FALL

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
4 HOURS

4 HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION ON COUMADIN THERAPY

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

01/29/08

28b. Time of Injury

8 A M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

FALL IN DECEDANTS HOME

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State)  
7919 RUXWAY ROAD TOWSON, MARYLAND

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D47625

29d. Date signed (Month, Day, Year)

1/30/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD O'MALLEY M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10+1

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02630

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM MICHAEL KILBOURNE

2. Date of Death

JAN 26 2008

3. Time of Death

4:23 P M

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

None

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 17, 2008

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Montgomery Village

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8846 Thomas Lea Terrace

10f. Zip Code

20886

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
0

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. Do NOT use retired)

None

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Michael J. Kilbourne

18. Mother's Name (First, Middle, Maiden Surname)

Carly R. Ellenberger

19a. Informant's Name/Relationship (Type, Print)

Michael J. Kilbourne/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8846 Thomas Lea Terrace, Montgomery Village, MD 20886

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Montgomery  
Crematorium, Inc.

Date

January 31,  
2008

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

R. J. [Signature]

22. Name and Address of Facility

Robert A. Humphrey Funeral Home/Chase, Inc.  
7557 Wisconsin Ave., Bethesda, MD 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. EXTREME PREMATUREITY

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier

(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Nicole R. Dobson, MD

29c. License number

25MA07382700 (NJ)

29d. Date signed (Month, Day, Year)

01/28/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NICOLE R. DOBSON CPT MC USA

NATIONAL NAVAL MEDICAL CENTER  
BETHESDA MD 20889-5600

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760, 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02631

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RITA

K

KRONGARD

2. Date of Death  
Month Day Year

January 30 2008

3. Time of Death

02:30 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

220-40-9806

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

8. Date of Birth (Month, Day, Year)

08/14/1911

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

LUTHERVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

202 BRIGHTWOOD CLUB ROAD

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ABRAHAM

KEYSER

18. Mother's Name (First, Middle, Maiden Surname)

ETHEL

UNOBTAINABLE

19a. Informant's Name/Relationship (Type, Print)

ALVIN KRONGARD / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1400 W. SEMINARY AVE., LUTHERVILLE, MD 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place)

AGUDAS ACHIM ANSHE SFARD CONG.

Date

01/31/2008

20c. Location - City or Town, State

ROSEDALE, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Mitral Regurgitation. Breast Cancer w/ Radiation therapy

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Kapil Gangwal M.D.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

January 30, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kapil Gangwal, MD, Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

State Registrar

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02632

1- For  
State  
Registrar

|   |   |  |   |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>ELAINE KLINE</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>JANUARY 29, 2008</b>  |  | 3. Time of Death<br><b>1:53AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Saint Joseph Medical Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Towson</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>213-28-4645</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   |  | 8. Date of Birth (Month Day Year)<br><b>04/03/1928</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTIMORE</b>  |  | 10c. City, Town or Location<br><b>PIKESVILLE</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>13 POMONA SOUTH, APT. 4</b>  |  | 10f. Zip Code<br><b>21208</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>LOUIS FISHER</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SARAH MAGED</b>  |  |  |  |
| Physician<br>/Medical<br>Examiner             | 19a. Informant's Name/Relationship (Type, Print)<br><b>GAIL KUSHNER / DAUGHTER</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10701 BOSWELL LANE, POTOMAC, MD 20854</b>  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARLINGTON CHIZUK AMONO CONG.</b>   |  | Date<br><b>01/31/2008</b>  |  | 20c. Location - City or Town, State<br><b>BALTIMORE, MD</b>  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>Michael Dwyer</i>   |  |   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CEREBRAL BLEED</b><br>a. Due to (or as a consequence of):<br><b>HEMORRHAGIC STROKE</b><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |  |  |  | Approximate Interval Between Onset and Death |
| To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death<br>9 <input type="checkbox"/> Unknown   |  | 3 <input type="checkbox"/> Ectopic pregnancy<br>5 <input type="checkbox"/> Other (specify)   |  | 23d. Date of delivery<br>Month Day Year  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i>  |  | 29c. License number<br><b>D46356</b>   |  |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)<br><b>January 29, 2008</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>KHOSROW TABASSI M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204</b>   |  | 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>  |  |  |  |
|   | 32. Registrar's Signature<br><i>[Signature]</i>   |  | 33. State Registrar<br><b>State Registrar</b>   |  |  |  |  |  |

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2008 02633

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy S. Leftwich

2. Date of Death

Month 01 Day 29 Year 2008

3. Time of Death

7:05 A. M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Gilchrist Hospice

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

220-09-5939

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

4/09/1920

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6131 North Charles Street

10f. Zip Code

21212

10g. Citizen of What Country?

United States

of America

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Librarian

16b. Kind of Business/Industry

Private Schools

17. Father's Name (First, Middle, Last)

Anton J. Schwartz

18. Mother's Name (First, Middle, Maiden Surname)

Nina B. Schwartz

19a. Informant's Name/Relationship (Type, Print)

Douglas L. Leftwich Jr./ spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6131 North Charles St. Baltimore, Maryland 21212

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel-

Bel Air

Date

January

31, 2008

20c. Location - City or Town, State

Forest Hill, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Peaceful Alternatives Funeral &amp; Cremation Ctr., P.A.

2325 York Road Timonium, Maryland 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION  
Due to (or as a consequence of):Approximate Interval Between Onset and Death  
DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. GASTROINTESTINAL BLEEDING  
Due to (or as a consequence of):

DAYS

c. ANTI COAGULATION  
Due to (or as a consequence of):

YEARS

d. ATRIAL FIBRILLATIONS  
Due to (or as a consequence of):

YEARS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LUPUS

DIABETES

CHRONIC WOUNDS

THROMBOCYTOPENIA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D64395

29d. Date signed (Month, Day, Year)

JANUARY 29, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIELLE DOBERMAN, MD 6565 N CHARLES ST. SUITE 209 BALTIMORE, MD 21204

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 44

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

## Certificate of Death

Reg. No. 2008 02634

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margene Haines Lawson

2. Date of Death

Month Day Year  
JANUARY 27, 2008

3. Time of Death

12:45 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

FutureCare Nursing Home

4b. City, Town, or Location of Death

Arnold

4c. County of Death

Anne Arundel

5. Social Security Number

273-16-9406

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 1, 1920

9. Birthplace (State or Foreign Country)

OH

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9 Bellevue Dr.

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John O. Woodnanssee

18. Mother's Name (First, Middle, Maiden Surname)

Laura Luttrell

19a. Informant's Name/Relationship (Type, Print)

Donna Spencer Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 Bellevue Dr., Severna Park, MD 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sugar Grove Cemetery

Date

January 31, 2008

20c. Location - City or Town, State

Wilmington, OH

21. Signature of Funeral Service Licensee

K. Gregory Fink M01148

22. Name and Address of Facility

Fink Funeral Home, P.A.  
426 Crain Hwy S., Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D35037

29d. Date signed (Month, Day, Year)

28 JAN 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D MITCHELL MD 2001 MEDICAL PARKWAY, ANNAPOLIS MD 21404

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

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Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02635

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

SUSAN MARIE DRIVER STEINMACHER BROYHILL LIEDEL

2. Date of Death

JANUARY 25, 2008

3. Time of Death

9:05 A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

212-50-0768

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60

8. Date of Birth (Month, Day, Year)

Nov. 15, 1947

9. Birthplace (State or Foreign Country)

Maryland

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Forest Hill

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1712 Unit J Landmark Drive

10f. Zip Code

21050

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

Home Construction

17. Father's Name (First, Middle, Last)

Thomas Hamilton Driver Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Doris Marcella Glenn

19a. Informant's Name/Relationship (Type, Print)

Leslie A. Driver / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1604 Martha Court, Bel Air, Maryland 21015

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Grdn 1-29-08

Date

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McComas Funeral Home, P.A.  
1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

OVARIAN CANCER

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

11/28/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD, M.D.

2300 DULANEY VALLEY ROAD

TIMONIUM MD 21093

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

ORIGINAL

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

JANUARY 25, 2008 9:05 A.M. Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 44

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02636

1- For State

Registrar

1. Decedent's Name (First, Middle, Last) **Joseph Christopher McNeill, Jr.**2. Date of Death  
Month Day Year  
January 26, 20083. Time of Death  
1049 hrs4a. Facility Name (if not institution, give street and number)  
St. Agnes Hospital4b. City, Town, or Location of Death  
Baltimore4c. County of Death  
N/A5. Social Security Number  
216-62-09056. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
53 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth (MM/DD/YYYY)  
11/01/19549. Birthplace (State or Foreign Country)  
NC

Usual Residence of Decedent

10a. State  
MD10b. County  
N/A10c. City, Town or Location  
Baltimore10d. Inside City Limits  
1 ☒ Yes 2 ☐ No10e. Street and Number  
301 Kingston Road10f. Zip Code  
2122910g. Citizen of What Country?  
USA11. Marital Status  
1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S. Armed Forces?  
1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No specify:14. Race - American Indian, Black, White, etc.  
Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Law Clerk

16b. Kind of Business/Industry

U.S. Army

17. Father's Name (First, Middle, Last)  
Joseph C. McNeill Sr.18. Mother's Name (First, Middle, Maiden Surname)  
Margaret Carter19a. Informant's Name/Relationship (Type, Print)  
Patrice Taylor19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133  
4120 Tiverton Road Randallstown, MD20a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:20b. Place of Disposition (Name of cemetery, crematory or other place)  
Garrison ForestDate  
2/4/200820c. Location - City or Town, State  
Owings Mills, MD21. Signature of Funeral Service Licensee  
Vaughn C. Greene22. Name and Address of Facility  
Vaughn C. Greene Funeral Svc.  
8728 Liberty Rd. Randallstown, MD 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Head Injuries with Complications

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED☒ AMENDED  
#1, per ME, g876, 2/14/08 TT 23a, 27, 28a-f per ME g878 4/4/08 amh

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☒ Yes 2 ☐ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☐ Natural5 ☐ Pending Investigation2 ☒ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide28a. Date of Injury (Month, Day, Year)  
200228b. Time of Injury  
Unk28c. Injury at Work?  
1 ☐ Yes 2 ☒ No28d. Describe how injury occurred  
Subject fell at home28e. Place of Injury - At home, farm, street, factory, office building, etc.  
(Specify) Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State) 301 Kingston Rd., Balto, MD

29a. Certifier (Check only one)  
1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.29b. Signature and title of certifier  
Theodore M. King, Jr., MD29c. License number  
O.C.M.E.

OCME

29d. Date signed (Month, Day, Year)  
January 27, 200830. Name and address of person who completed cause of death (Item 23a)  
Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)  
FEB 01 2008

32. Registrar's Signature

ORIGINAL

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

2008 02637

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02638

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Drueding Maguire

2. Date of Death

January 31, 2008

3. Time of Death

9:20A M

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

220-46-5121

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

3/15/1948

9. Birthplace (State or Foreign Country)

Balt., Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9 Tintern Court

10f. Zip Code

21093

10g. Citizen of What Country?

United States  
of America

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Consultant

16b. Kind of Business/Industry

Telecommunications

17. Father's Name (First, Middle, Last)

Edward Charles Maguire

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Helen McCarthy

19a. Informant's Name/Relationship (Type, Print)

Helen T. Maguire/ sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

32 Wesmond Drive Alexandria, Virginia 22305

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral

Chapel - Bel Air

Date

February

1, 2008

20c. Location - City or Town, State

Forest Hill, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Peaceful Alternatives Funeral &amp; Cremation Ctr., P.A.

2325 York Road Timonium, Maryland 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ANOXIC ENCEPHALOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death Check only one

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. J. Helou, M.D.

29c. License number

D0017695

29d. Date signed (Month, Day, Year)

January 31, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDALLAH J. HELOU M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760, 444

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02639

1-

For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Patricia E. Mills

2. Date of Death

January 31, 2008

3. Time of Death

9:44 A.M.

4a. Facility Name (If not institution, give street and number)

114 Church Road

4b. City, Town, or Location of Death

Owings Mills

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

219-16-9298

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 27, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Owings Mills

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

114 Church Road

10f. Zip Code

21117

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☐ Never Married 2 ☐ Married☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Clarence Joseph Moran

18. Mother's Name (First, Middle, Maiden Surname)

Ola Rowzee

19a. Informant's Name/Relationship (Type, Print)

Frank H. Mills, III (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

85 West Sunshine Way, Westminster, Maryland 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Garrison Forest

Veterans Cemetery

Date

Feb. 5,

2008

20c. Location - City or Town, State

Owings Mills, Maryland

21. Signature of Funeral Service Licensee

Eckhardt Funeral Chapel, P.A.

22. Name and Address of Facility

11605 Reisterstown Road, Owings Mills, MD 21117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

&gt; 2 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ayman Akkard, MD 2600 Osler Dr. #411 Towson, MD 21204

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For amend #8 Per FH G879 5/30/08 in State of Maryland / Department of Health and Mental Hygiene 2008 02640  
 Registrar Certificate of Death

Reg. No.

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Hayfa Morrison</b>  |  | 2. Date of Death<br>Month <b>January</b> Day <b>22</b> Year <b>2008</b>  |  | 3. Time of Death<br><b>2009 M</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>The Johns Hopkins Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>  |  | 4c. County of Death   |
| Funeral<br>Director  | 5. Social Security Number<br><b>218.79.2384</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>Yrs. <b>4</b>  | 8. Date of Birth (Month, Day, Year)<br><b>09.08.2007</b> | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |
|  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Pikesville</b>  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>726 Leafy Terrace</b>   |  | 10f. Zip Code<br><b>21208</b>   |
|  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |
|  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b> College (1-4or 5+) <b>N/A</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>N/A</b>  |  | 16b. Kind of Business/Industry<br><b>N/A</b>  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Illzar Bhin Rhadyd</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Muriel Morrison</b>  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Muriel Morrison/Mother</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>726 Leafydale Terrace, Baltimore, MD 21208</b>                                     |  |   |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crem.</b>  |  | 20c. Location - City or Town, State<br><b>Beltsville, MD</b>  |
|  | 21. Signature of Funeral Service Licensee<br><b>L. Laue Better</b>   |  | 22. Name and Address of Facility<br><b>CAFA/Stephen D. Lohrmann, P.A.<br/>8717 Green Pastures Dr. Baltimore, MD</b>  |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Pulmonary hypertension</b><br>Due to (or as a consequence of):<br>b. <b>Pulmonary hypoplasia</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>4 months</b><br><b>4 months</b> |  |  |  |   |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year                              |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Trisomy 21, congenital hypothyroidism,<br/>Gram negative urinary tract infection, right<br/>ventricular heart failure</b><br>23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)<br>26. Place of Death (Check only one)<br>27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined<br>28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>29b. Signature and title of certifier<br><b>W. Christopher Shields, MD</b><br>29c. License number<br><b>D0056568</b><br>29d. Date signed (Month, Day, Year)<br><b>January 22, 2008</b>  |  |  |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>William Christopher Golden, 600 North Wolfe Street, Baltimore, Maryland 21287</b>   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b><br>32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |  |   |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760, 44  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02641

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Jo Seminaris Mullin

2. Date of Death

Month Day Year  
Jan. 29, 2008

3. Time of Death

8:49 P M

4a. Facility Name (If not institution, give street and number)

Gilchrist Hospice Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

577.20.0187

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
08.22.1912

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

230 Stony Run Lane Apt. 5D

10f. Zip Code

21210

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Joseph Seminaris

18. Mother's Name (First, Middle, Maiden Surname)

Anna Seminaris

19a. Informant's Name/Relationship (Type, Print)

Dana Lewison/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

230 Stony Run Lane Apt. 5D, Baltimore, MD 21210

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

01.30.08

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Dana Lewison M01143

22. Name and Address of Facility

Cremation And Funeral Alternatives  
8717 Green Pastures Dr. Balto., MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Complications of dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Seminaris

29c. License number

D 58303

29d. Date signed (Month, Day, Year)

January 30 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aaron J CHARLES MD 6701 N. Charles St Towson MD 21204

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760, 44

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02642

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

John E. Mettille

2. Date of Death

Jan 31 2008

3. Time of Death

12:10 AM

4a. Facility Name (If not institution, give street and number)

12 Spinnaker Reef Court

4b. City, Town, or Location of Death

Middle River

4c. County of Death

Baltimore

5. Social Security Number

212-20-7298

6. Sex

X M 2 F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Dec. 14, 1919

9. Birthplace (State or Foreign Country)

Iowa

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

12 spinnaker Reef Court

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12th

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Iron Worker

16b. Kind of Business/Industry

Whiting &amp; Turner

17. Father's Name (First, Middle, Last)

John A. Mettille

18. Mother's Name (First, Middle, Maiden Surname)

Mary M. McCormick

19a. Informant's Name/Relationship (Type, Print)

Dianne Kelly /daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 Spinnaker Reef Court Balto. MD 21220

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Belair Memorial

Date

2/5/08

20c. Location - City or Town, State

Belair MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

300 Mace Ave. Baltimore MD

Connelly Funeral Home of Essex 21221

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

COPD

Approximate Interval Between Onset and Death

2 WKS

b. Due to (or as a consequence of):

5 yrs.

c. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

3 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

3 Ectopic pregnancy

4 Pregnant at time of death

5 Other (specify)

9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death Check only one

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 0057021

29d. Date signed (Month, Day, Year)

01/31/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RITA MATHUR, M.D 9106 Philadelphia Rd Ste 106 Baltimore, MD 21237

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02643

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Michael W. March

2. Date of Death

January 29, 2008

3. Time of Death

5:20 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

212-48-2178

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 21, 1948

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1313 Gunpowder Crossing Lane

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

John William March Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Janowich

19a. Informant's Name/Relationship (Type, Print)

April White /sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1313 Gunpowder Crossing Lane Balto. MD

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory

Date

1/31/08

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

300 Mace Ave. Balto. MD

Connelly Funeral Home of Essex 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End stage Liver Disease

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hepatitis C

3 years

c. Hypertension

10 years

d. Small bowel ischemia

8 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Strangulated hernia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

January 29, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Adrianna J. Jackson, M.D. Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

State Registrar

March, Michael  
Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02644

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Serena Millsthornton

2. Date of Death

Month

Day

Year

01

21

2008

3. Time of Death

10:10PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN NURSING CTR

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

214-12-0483

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan 15, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4614 Elsrode Avenue

10f. Zip Code

21214

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

poet/writer

16b. Kind of Business/Industry

journalism

17. Father's Name (First, Middle, Last)

Frank Lewis

18. Mother's Name (First, Middle, Maiden Surname)

Germaine Franklin

19a. Informant's Name/Relationship (Type, Print)

Susan Brown/god daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 47183 Baltimore, MD 21244

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ASCVD

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of):

Severe PVD

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D57727

29d. Date signed (Month, Day, Year)

1/24/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Grendel Sharan 8813 Walthermoores Road MD 21234

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02645

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HARRY McALLISTER

2. Date of Death  
Month Day Year

JANUARY 24 2008

3. Time of Death

7:19 PM

4a. Facility Name (If not institution, give street and number)

Mercy Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

215-85-9930

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44

8. Date of Birth (Month, Day, Year)

Jan 7, 1964

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

601 S. Charles Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10College (1-4or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

plumber

16b. Kind of Business/Industry

unk

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

Paulette McAllister/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1212 Paul martin Drive Edgewood, MD 21040

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Coronary artery disease

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

13 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ryan McCormack MD

29c. License number

D0063066

29d. Date signed (Month, Day, Year)

January 24, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

301 Saint Paul Place, Baltimore, MD 21203

Ryan McCormack, MD

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02646

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HAROLD IRVIN MASTER

2. Date of Death

January 28 2008 12:41 AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MARINER Health in Bel Air

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

216-16-8372

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

8. Date of Birth

May 17, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1704 Gatehouse Ct.

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Entrepreneur

16b. Kind of Business/Industry

Commercial

Landscaping Equipment

17. Father's Name (First, Middle, Last)

Raymond Thomas Master

18. Mother's Name (First, Middle, Maiden Surname)

Edith Blessing Barnitz

19a. Informant's Name/Relationship (Type, Print)

Elizabeth B. Master / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1704 Gatehouse Ct., Bel Air, Maryland 21014

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp 1-29-08

Date

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

McComas Funeral Home, P.A.  
1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D28136

29d. Date signed (Month, Day, Year)

1-29-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 W. McPherson Rd Bel Air, MD 21014

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, HAROLD IRVIN MASTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No.

2008 02617

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carolyn

2. Date of Death

January 29 2008

3. Time of Death

5:20 aM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore city

4c. County of Death

5. Social Security Number

196-38-1755

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61

8. Date of Birth (Month, Day, Year)

Oct. 5, 1946

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3907 Walters Road

10f. Zip Code

21040

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S. Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian, Black, White, etc.  
Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Office Manager

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Orlando (unk) Deflice

18. Mother's Name (First, Middle, Maiden Surname)

Lucy (UNK) (UNK)

19a. Informant's Name/Relationship (Type, Print)

Steven C. Siler / Companion

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3907 Walters Rd., Edgewood, MD 21040

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gdn

Date

2-1-08

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

Stella A. Hughes

22. Name and Address of Facility

McComas Funeral Home, P.A.  
1317 Cokesbury Rd., Abingdon, MD 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Stage IV breast cancer with systemic metastasis

Approximate Interval Between Onset and Death

2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. methesiline susceptible staph aureus bacteremia

4 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Heart Failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ea MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

January 29 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Bath, 600 North Wolfe Street, Baltimore MD 21287

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Ly.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02548

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Leroy Mackall

2. Date of Death

1/25/08

3. Time of Death

8:30 PM

4a. Facility Name (If not institution, give street and number)

Genesis Lochraven

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

220-38-6538

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

3/30/41

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

613 Otter Creek Rd.

10f. Zip Code

21040

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

NA

17. Father's Name (First, Middle, Last)

Leroy Stanley

18. Mother's Name (First, Middle, Maiden Surname)

Aurelia Mackall

19a. Informant's Name/Relationship (Type, Print)

Lisa Mackall-Conigland Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

613 Otter Creek Rd. Edgewood, MD 21040

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Cem

Date

1/30/08

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Bernard D Johnson

22. Name and Address of Facility

March F/H East 1101 East North Ave Baltimore, MD 21202

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Cancer of colon

Due to (or as a consequence of):

b. Cerebrovascular disease

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dwight Trupenaen

29c. License number

D 30661

29d. Date signed (Month, Day, Year)

January 23<sup>rd</sup> 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3601 Loch Raven Blvd. Baltimore. Md-21239

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2008 02649

|   |  |   |  |
|---|--|---|--|
| 1. For State Registrar  |  | Reg. No.  |  |
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month Day Year  |  |
| Sidney Roland Millner III   |  | January 26, 2008  |  |
| 3. Time of Death<br>1345 hrs  |  | 4c. County of Death<br>NA   |  |
| 4a. Facility Name (if not institution, give street and number)  |  | 4b. City, Town, or Location of Death  |  |
| University of Maryland Medical Center   |  | Baltimore   |  |
| 5. Social Security Number   |  | 6. Sex  |  |
| 217-13-7403   |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  |
| 7. Age (In yrs. last birthday)  |  | 8. Date of Birth (MM/DD/YYYY)   |  |
| 25 Yrs.   |  | 2/2/82  |  |
| 9. Birthplace (State or Foreign Country)  |  | MD  |  |
| Usual Residence of Decedent   |  | 10d. Inside City Limits   |  |
| 10a. State  |  | 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| MD  |  | NA  |  |
| 10b. County   |  | 10c. City, Town or Location   |  |
| NA  |  | Baltimore   |  |
| 10e. Street and Number  |  | 10f. Zip Code   |  |
| 1002 Bennett Pl.  |  | 21223   |  |
| 10g. Citizen of What Country?   |  | U.S.A   |  |
| 11. Marital Status  |  | 12. Was Decedent Ever in U.S. Armed Forces?   |  |
| 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married  |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | If Yes, Give Year or Dates  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  |  | 14. Race - American Indian, Black, White, etc.  |  |
| 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:  |  | Specify: Black  |  |
| 15. Decedent's Education (Specify only highest grade completed)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   |  |
| Elementary/Secondary (0-12)   |  | 16b. Kind of Business/Industry  |  |
| College (1-4 or 5+)   |  | NA  |  |
| 12th Grade  |  | Student   |  |
| 17. Father's Name (First, Middle, Last)   |  | 18. Mother's Name (First, Middle, Maiden Surname)   |  |
| Sidney R. Millner Jr.   |  | Angela White  |  |
| 19a. Informant's Name/Relationship (Type, Print)  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |  |
| Sidney R. Millner Jr. Father  |  | 1002 Bennett Pl. Baltimore, Md 21223  |  |
| 20a. Method of Disposition  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State   |  | Date  |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:   |  | Trinity 2/1/08  |  |
| 21. Signature of Funeral Service Licensee   |  | 22. Name and Address of Facility  |  |
| Bernard D. Johnson  |  | March F/H East  |  |
| 1101 East North Ave Baltimore, MD 21202   |  | 23d. Date of delivery   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.       |  | Approximate Interval Between Onset and Death  |  |
| Immediate Cause (Final disease or condition resulting in death)   |  |   |  |
| a. Multiple Gunshot Wounds  |  |   |  |
| Due to (or as a consequence of):  |  |   |  |
| b.  |  |   |  |
| Due to (or as a consequence of):  |  |   |  |
| c.  |  |   |  |
| Due to (or as a consequence of):  |  |   |  |
| d.  |  |   |  |
| UNPENDED  |  | AMENDED   |  |
| IF FEMALE:  |  | 23c. If yes, outcome of pregnancy   |  |
| 23b. Was decedent pregnant in the past 12 months?   |  | 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy   |  |
| 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)   |  | Month Day Year  |  |
| 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  | 9 <input type="checkbox"/> Unknown  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23e. Did tobacco use contribute to the cause of death?  |  |
|   |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |
|   |  | 24a. Was an autopsy performed?  |  |
|   |  | 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   |  | 24b. Were autopsy findings available prior to completion of cause of death?   |  |
|   |  | 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?  |  | 26. Place of Death (Check only one)   |  |
| 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other: |  |
| 27. Manner of Death   |  | 28a. Date of Injury (Month, Day, Year)  |  |
| 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation   |  | Jan 24, 2008  |  |
| 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28b. Time of Injury   |  |
| 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide   |  | 1736 hrs  |  |
|   |  | 28c. Injury at Work?  |  |
|   |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|   |  | 28d. Describe how injury occurred   |  |
|   |  | Subject shot  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc.  |  |
|   |  | (Specify) Store   |  |
|   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
|   |  | 1154 N. Stricker Street, Baltimore, MD  |  |
| 29a. Certifier (Check only one)   |  | 29c. License number   |  |
| 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | O.C.M.E.  |  |
| 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29d. Date signed (Month, Day, Year)   |  |
| 29b. Signature and title of certifier   |  | January 28, 2008  |  |
| Patricia Aronica-Pollak MD. Assistant Medical Examiner  |  | 111 Penn Street, Baltimore, MD 21201  |  |
| 31. Date filed (Month, Day, Year)   |  | 32. Registrar's Signature   |  |
| FEB 01 2008   |  |   |  |

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02650

## Certificate of Death

Reg. No.

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Mabel Lee Nowlin

2. Date of Death

January 31, 2008

3. Time of Death

1:35 P.M.

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

5. Social Security Number

218-10-8630

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 14, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7309 Second Ave.

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Charles Levi Filbert

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Struder

19a. Informant's Name/Relationship (Type, Print)

Howard W. Jones - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Orchard Place, Sykesville, Md. 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cem. Feb. 8, 2008 Owings Mills, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

H. E. Eckhardt

22. Name and Address of Facility

Eckhardt Funeral Chapel, P.A.,  
Owings Mills, Md. 21117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Benjamin E. Eckhardt, MD

Randallstown, Md. 21133

32. Registrar's Signature

31. Date filed (Month, Day, Year)

FEB 01 2008

State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760, 442 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 10c, e, f, per fh 8876 2-1-08 vt

State of Maryland Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 02651

1- For State Registrar

Physician /Medical Examiner

Funeral Director

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last)<br>William Stanley Polinsky  |  | 2. Date of Death<br>Month Day Year<br>January 30, 2008  |   | 3. Time of Death<br>5:40 P <sup>M</sup>  |   |
| 4a. Facility Name (If not institution, give street and number)<br>Greater Baltimore Medical Center  |  | 4b. City, Town, or Location of Death<br>Towson  |   | 4c. County of Death<br>Baltimore   |   |
| 5. Social Security Number<br>040-44-6324  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>58 Yrs.   | If Under 1 Year<br>Months Days Hours Min.                             | 8. Date of Birth (Month, Day, Year)<br>8/29/1949   | 9. Birthplace (State or Foreign Country)<br>Connecticut |
| Usual Residence of Decedent   |  |   |   |  |   |
| 10a. State<br>Maryland  | 10b. County<br>Baltimore   | 10c. City, Town or Location<br><del>Sparks</del> Timonium   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |
| 10e. Street and Number<br><del>1 D Wind Mill Chase</del> 8C Quiet Stream Court  |  | 10f. Zip Code<br><del>21152</del> 21093   |   | 10g. Citizen of What Country?<br>United States of America  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 1  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Sales Manager  |   | 16b. Kind of Business/Industry<br>Computer Technology  |   |
| 17. Father's Name (First, Middle, Last)<br>Stanley Polinsky   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Dorothy Sinnamon |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Barbara J. Polinsky/ wife   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1 D. Wind Mill Chase Sparks, Maryland 21152  |   |  |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Evans Funeral Chapel - Bel Air  |   | 20c. Location - City or Town, State<br>January 31, 2008 Forest Hill, Maryland  |   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>Peaceful Alternatives Funeral & Cremation Ctr., P.A.<br>2325 York Road Timonium, Maryland 21093   |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>a. pulmonary edema<br>b. coronary artery disease<br>c.<br>d.   |  |   |   |  |   |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |   |   |  |   |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____   |  |   |   |  |   |
| 23d. Date of delivery<br>Month Day Year   |  |   |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>renal insufficiency   |  |   |   |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |   |  |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |   |
|   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |   |
|   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |   |
| 29b. Signature and title of certifier<br>Cynthia Soriano MD   |  | 29c. License number<br>D0051347   |   | 29d. Date signed (Month, Day, Year)<br>1/30/08   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Cynthia Soriano MD 6701 N. Charles St. Baltimore MD 21204   |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br>FEB 01 2008  |  | 32. Registrar's Signature<br>   |   |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02652

1-

For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nathaniel James Pennington

2. Date of Death  
Month Day Year

January 23 2008

3. Time of Death

1045 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Maryland

5. Social Security Number

213-65-1848

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

5

8. Date of Birth (Month, Day, Year)

August 8, 2002

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3411 Brendan Ave.

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
N/A

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Christopher J. Pennington

18. Mother's Name (First, Middle, Maiden Surname)

Amanda Spearman

19a. Informant's Name/Relationship (Type, Print)

Amanda Spearman- Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3411 Brendan Ave., Baltimore, Maryland 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Park

Date

Jan. 30, 2008

20c. Location - City or Town, State

Elkridge, Maryland

21. Signature of Funeral Service Licensee

M. J. H. 201234

22. Name and Address of Facility

Fleck Funeral Home, INC.  
7601 Sandy Spring Rd., Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular Fibrillation  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hyperkalemia  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hunters Disease

Chronic Lung Disease

Hydrocephalus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael C. My M.D.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

January 23, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael McCrory M.D. 600 North Wolfe Street Baltimore, MD 21287

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02653

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Archontoula Papadopoulos

2. Date of Death

January 29, 2008

3. Time of Death

10:25PM M

4a. Facility Name (If not institution, give street and number)

4220 McCain Court

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-42-1853

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 11, 1930

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4220 McCain Court

10f. Zip Code

20895

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Employment Manager

16b. Kind of Business/Industry

Capital Hilton Hotel

17. Father's Name (First, Middle, Last)

Peter S. Mantis

18. Mother's Name (First, Middle, Maiden Surname)

Argyro Papakonstantinou

19a. Informant's Name/Relationship (Type, Print)

Georgia Coffey / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14038 Weeping Cherry Drive, Rockville, MD 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Glenwood Cemetery

Date

February 2,  
2008

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service Licensee

M01473

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue  
Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
Minutes

b. Diabetes

Due to (or as a consequence of):

Years

c. Hyperlipidemia

Due to (or as a consequence of):

Years

d. Hypertension

Due to (or as a consequence of):

Years

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D21392

29d. Date signed (Month, Day, Year)

January 30, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patricia Kellogg, M.D. 1201 Seven Locks Road, Ste. 111, Rockville, MD 20854

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 02654

1- For State Registrar

|   |   |   |   |  |  |  |   |  |
|---|---|---|---|--|--|--|---|--|
| Physician /Medical Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Lillian M. Quinn</b>   |   |   |  | 2. Date of Death<br>Month <b>01</b> Day <b>26</b> Year <b>2008</b>   |  | 3. Time of Death<br><b>19:00 PM</b>                                     |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Rosedale</b>  |  | 4c. County of Death<br><b>Baltimore</b>                                 |  |
| Funeral Director  | 5. Social Security Number<br><b>216-01-5890</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>09 23 1914</b>                |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |   |   |  |  |  |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |   |   |  |  |  |   |  |
|   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Nottingham</b>   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|   | 10e. Street and Number<br><b>7 Silverwood Ct.</b>   |   |   |  | 10f. Zip Code<br><b>21236</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Timekeeper</b>   |  | 16b. Kind of Business/Industry<br><b>Bendix Manufacturing</b>           |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Calvert L. Ford</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edna E. Cousler</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Pam Savage/Daughter</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7 Silverwood Ct. Nottingham MD 21236</b>   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulvaney Valley</b>  |  | Date<br><b>01/30/08</b>  |  | 20c. Location - City or Town, State<br><b>Timonium</b>                  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>   |   |   |  | 22. Name and Address of Facility<br><b>Schimunek Funeral Home Inc.<br/>9705 Belair Rd. Nottingham MD 21236</b>   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Myocardial Infarction</b><br>Due to (or as a consequence of):<br>b. <b>Influenza/Viral Syndrome</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   |  |  | 23d. Date of delivery<br>Month Day Year  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M               |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |   | 28d. Describe how injury occurred      |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.              |   | 29b. Signature and title of certifier<br><b>[Signature]</b>   |   | 29c. License number<br><b>D0051014</b> |  | 29d. Date signed (Month, Day, Year)<br><b>1/26/08</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ERIC C. NACEN Franklin Square Hospital Drive 21237</b>   |   |   |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>   |   | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For amend #30 Per DVR G876 2/01/08, JH  
Registrar  
Certificate of Death

Reg. No. 2008 02655

|  |   |  |   |   |  |                          |   |   |   |   |  |  |  |
|--|---|--|---|---|--|--------------------------|---|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>James A. Quick</b>   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>January 25 2008</b>   |                          |   |   | 3. Time of Death<br><b>0135</b> M   |   |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>Easton</b>  |                          |   |   | 4c. County of Death<br><b>Talbot</b>  |   |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-01-0585</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.   |                          | 8. Date of Birth (Month, Day, Year)<br><b>July 28, 1918</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                                       |   |  |  |  |
|  | Usual Residence of Decedent   |  |   |   | 10a. State<br><b>MD</b>  |                          |   |   | 10b. County<br><b>Talbot</b>  |   | 10c. City, Town or Location<br><b>Easton</b> |  |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>610 Dutchmans Lane</b>   |  |   |   | 10f. Zip Code<br><b>21601</b>  |                          |   |   | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |                          |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                               |   |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unk</b> College (1-4or 5+) <b>unk</b>   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>butcher</b>  |                          |   |   | 16b. Kind of Business/Industry<br><b>grocery store</b>  |   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Arthur Alexander Quick</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pearl Norwood</b>  |                          |   |   |   |   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Quick/spouse</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9510 Service Lane Easton, MD 21601</b>   |                          |   |   |   |   |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |                          | Date  |   | 20c. Location - City or Town, State   |   |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>  |  |   |   | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>   |                          |   |   |   |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Chronic Obstructive Pulmonary Disease</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   | Approximate Interval Between Onset and Death<br><b>72 years</b>  |                          |   |   |   |   |  |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 Unknown   |  |   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br>9 Unknown |                          |   |   | 23d. Date of delivery<br>Month Day Year   |   |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Sick Sinus Syndrome</b><br><b>Sleep Apnea</b><br><b>Chronic Atrial fibrillation</b>  |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |                          |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                          |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   |  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred                     |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |                          |   |   |   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   | 29b. Signature and title of certifier<br><b>Carolyn Sue Helmly MD</b>   |  |                          |   | 29c. License number<br><b>D0053602</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>1/25/08</b> |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Carolyn Sue Helmly Easton, Md. 21601</b>  |   |  |   |   |  |                          |   |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>  |   |  |   | 32. Registrar's Signature<br><b>[Signature]</b>   |  |                          |   |   |   |   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02656

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frederick Matthew Reinholdt Jr.

2. Date of Death

Month Day Year  
1 31 2008

3. Time of Death

11:20 A.M.

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

212-20-0212

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

11/3/1925

9. Birthplace (State or Foreign Country)

Balt., Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

6613 Pheasant Road

10f. Zip Code

21220

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Master Mechanic

16b. Kind of Business/Industry

Penn Central Railroad

17. Father's Name (First, Middle, Last)

Frederick Matthew Reinholdt Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Flora Mae Clark

19a. Informant's Name/Relationship (Type, Print)

Catherine E. Reinholdt/ dau.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6613 Pheasant Road Middle River, Maryland 21220

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel - Bel Air

Date

February 1, 2008

20c. Location - City or Town, State

Forest Hill, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Peaceful Alternatives Funeral & Cremation Ctr., P.A.  
2325 York Road Timonium, Maryland 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Aspirating pneumonia*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Parkinson disease*  
Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D58303

29d. Date signed (Month, Day, Year)

January 31 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARON J. CHARLES and 6701 N. Charles St Towson MD 21204

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

*[Signature]*

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68766

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02657

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph S. Rider, Jr.

2. Date of Death  
Month Day Year  
January 30, 20083. Time of Death  
6:14 P<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Dove House

4b. City, Town, or Location of Death  
Westminster4c. County of Death  
CarrollFuneral  
Director5. Social Security Number  
217-22-79296. Sex  
☒ M ☐ F7. Age (In yrs. last birthday)  
79 Yrs.8. Date of Birth  
(Month, Day, Year)  
May 23, 19289. Birthplace (State or Foreign Country)  
Maryland

Usual Residence of Decedent

10a. State  
MD10b. County  
Carroll10c. City, Town or Location  
Westminster10d. Inside City Limits  
☐ Yes ☒ No

10e. Street and Number

552 Houck Rd.

10f. Zip Code

21157

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates: Korea13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)  
Elementary/Secondary (0-12) 9  
College (1-4 or 5+)16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)  
Route Salesman16b. Kind of Business/Industry  
Bake Goods

17. Father's Name (First, Middle, Last)

Joseph S. Rider, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Emma Bricker

19a. Informant's Name/Relationship (Type, Print)

Dorothy Rider / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

552 Houck Rd. Westminster, MD 21157

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)  
Maryland Veterans  
Cemetery

Date

2/7/08

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
Eckhardt Funeral Chapel P.A.  
11605 Reisterstown Rd. Owings Mills, MD 2111723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. metastatic carcinoma of unknown primary  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None Known

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an  
autopsy  
performed?  
☐ Yes ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
☐ Yes ☐ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify) Inpatient hospice

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury  
M28c. Injury at  
Work?  
☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 15552

29d. Date signed (Month, Day, Year)

1/31/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard S. Rider, M.D. 555 S. Center St. Westminster, Md. 21157

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760, 44

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1- For  
State  
Registrar

Certificate of Death

Reg. No. 2008 02658

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Matthew Randolph</b>  |  | 2. Date of Death<br>Month <b>January</b> Day <b>23</b> Year <b>2008</b>   |   | 3. Time of Death<br><b>12:45</b> M  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Mercy Medical Center</b>  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |   | 4c. County of Death<br><b>City</b>  |   |
| 5. Social Security Number<br><b>218-26-8536</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>June 11, 1929</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
| Usual Residence of Decedent  |  | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Baltimore</b>   |   |
| 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |   |
| 10e. Street and Number<br><b>124 W. Franklin Street #1401</b>  |  | 10f. Zip Code<br><b>21201</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>   |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>0</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bookkeeper</b><br><del>delivery person</del>                                  |   |
| 16b. Kind of Business/Industry<br><b>Baltimore City Public Schools</b><br><del>school system</del>   |  | 17. Father's Name (First, Middle, Last)<br><b>unk</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>unk</b>   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Marion Edmondson/sister</b><br><del>Miriam Evanson/brother</del>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5313 Wabash Avenue Baltimore, MD 21215</b><br><del>State Anatomy Board 433 W. Baltimore Street</del>  |   |   |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>in state</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>Lansdowne, MD</b>   |   |
| 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>   |  | 22. Name and Address of Facility<br><b>Chapman Harris F.H. 5240 Reisterstown Rd. Baltimore, MD 21201 21215</b>  |   |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Ventricular Fibrillation</b><br>Due to (or as a consequence of):<br><b>b. Cardiomyopathy</b><br>Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  | 23b. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   | 23c. Date of delivery<br>Month _____ Day _____ Year _____   |   |
| 23d. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |   |   |
| 23f. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 23g. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |
| 24. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 25. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |
| 26. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 27a. Date of Injury (Month, Day Year)<br><b>M</b>   |   | 27b. Time of Injury<br><b>1</b> Yes <input type="checkbox"/> No   |   |
| 27c. Describe how injury occurred  |  | 27d. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |
| 28a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 28b. Signature and title of certifier<br><b>Karen A. Korzick, MD</b>  |   |   |   |
| 28c. License number<br><b>DY0744</b>   |  | 28d. Date signed (Month, Day, Year)<br><b>January 23, 2008</b>  |   |   |   |
| 29. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>K.A. Korzick, MD Mercy Medical Center</b>   |  | 30. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>   |   |   |   |
| 31. Registrar's Signature<br><b>[Signature]</b>  |  | 32. Date of Death<br><b>January 23, 2008</b>  |   |   |   |

# VOID

Karen Denise Romeo

certificate no.: 2008-02659

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH JULIA RILEY

2. Date of Death

Month Day Year  
JANUARY 30, 2008

3. Time of Death

17:22 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1303 Loflin Road

4b. City, Town, or Location of Death

Aberdeen

4c. County of Death

Harford

5. Social Security Number

214-14-8985

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 28, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1303 Loflin Road

10f. Zip Code

21001

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

John J. Berenger

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Julia Kadlec

19a. Informant's Name/Relationship (Type, Print)

Robert Chilcoat / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

312 Regal Drive, Abingdon, Maryland 21009

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Highview Memorial Gardens 2-4-08 Fallston, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McComas Funeral Home, P.A.  
1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. HYPERTENSION

Due to (or as a consequence of):

c. HYPERLIPIDEMIA

Due to (or as a consequence of):

d. CHRONIC RENAL DISEASE

18 years

18 years

2 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown  
3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Smoking

Carotid bruits

History of Atrial Fibrillation

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D. Gennino, MD

29c. License number

D46268

29d. Date signed (Month, Day, Year)

02/01/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gwenneth O. CANNINO

1200 Brassmill Rd, Belcamp, MD 21017

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #30, per DVR, G876, 2/1/08 T Certificate of Death

Reg. No. 2008 02661

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

MARY

EVA

RUDMAN

2. Date of Death

January 29 2008 4:30 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

FAHRNEY-KEEDY HOME &amp; VILLAGE

4b. City, Town, or Location of Death

BOONSBORO

4c. County of Death

WASHINGTON

5. Social Security Number

061-01-7860

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

8. Date of Birth (Month, Day, Year)

07/01/1916

9. Birthplace (State or Foreign Country)

ROMANIA

Usual Residence of Decedent

10a. State

MD

10b. County

FREDERICK

10c. City, Town or Location

MYERSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11643 MEETING HOUSE ROAD

10f. Zip Code

21773

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SEAMSTRESS

16b. Kind of Business/Industry

CLOTHING

17. Father's Name (First, Middle, Last)

HARRY

18. Mother's Name (First, Middle, Maiden Surname)

GERTSON

JENNY

LERNER

19a. Informant's Name/Relationship (Type, Print)

FRED L. RUDMAN / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11643 MEETING HOUSE ROAD, MYERSVILLE, MD 21773

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SHAAREI TFILOH CONG.

Date

01/31/2008

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic obstructive Pulmonary Disease

Due to (or as a consequence of):

b. Atrial Fibrillation

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30x

10x

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D52323

29d. Date signed (Month, Day, Year)

01-29-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Muhammad Khalid Waseem, MD Fahrney-Keedy Home &amp; Village Boonsboro, MD

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitMary E. Rudman  
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02662

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Katherine B. Schultz

2. Date of Death

January 28 2008

3. Time of Death

19:40 M

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

215-44-1413

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 9, 1921

9. Birthplace (State or Foreign Country)

BALTIMORE, MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

Glen Arm

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12246 Manor Road

10f. Zip Code

21057

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Carney Animal Hospital

17. Father's Name (First, Middle, Last)

Harry L. Schultz, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Esther G. Glaub

19a. Informant's Name/Relationship (Type, Print)

David Schultz - Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12246 Manor Rd, Glen Arm MD 21057

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

New Cathedral Cemetery

Date

2/1/08

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Kimberly A. Zupotay

22. Name and Address of Facility

8800 HARFORD RD, BALTIMORE, MD 21234.  
Evans Funeral Chapel + Cremation Services Parkville23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Clostridium Difficile Colitis

Approximate  
Interval Between  
Onset and Death

Days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension  
Alzheimers Dementia  
Breast Cancer Colon Cancer

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

K. H. Scruggs MD

29c. License number

D 13583

29d. Date signed (Month, Day, Year)

JANUARY 30, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KEVIN H. SCRUGGS MD

5601 LOCH RAVEN BOULEVARD  
BALTIMORE, MARYLAND 21239

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

K. H. Scruggs MD

State  
RegistrarSchultz, Katherine  
Baltimore, Maryland 21215-0036To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, 48



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2008 02663

1- For State  
Registrar

Reg. No.

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| Physician/<br>Medical Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Deborah Strother-Williams</b>  |  | 2. Date of Death<br>Month Day Year<br><b>January 25, 2008</b>   |  | 3. Time of Death<br><b>0929 hrs</b>  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Harbor Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>-----</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-84-9489</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>48</b> Yrs.  | If Under 1 Year<br>Months Days Hours Min.  | 8. Date of Birth (MM/DD/YYYY)<br><b>03-03-1959</b>   |
|   | 9. Birthplace (State or Foreign Country) <b>MD</b>  |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Glen Burnie</b>  |
|   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |
|   | 10e. Street and Number<br><b>308 W. Juneberry Way, Unit 1C</b>  |  | 10f. Zip Code<br><b>21061</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: |
|   | 14. Race - American Indian, Black, White, etc.<br><b>African American</b>   |  | Specify: <b>American</b>  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) <b>2+</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Case Manager</b>                      |  | 16b. Kind of Business/Industry<br><b>United Health Care</b>  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Leroy Brown</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lourena Neal</b>  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Tremayne Richardson - brother</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3621 Blair Ave., Randallstown, Maryland 21133</b> |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Mem. Pk.</b>   |  | 20c. Location - City or Town, State<br><b>Elkridge, Maryland</b>   |
|   | 21. Signature of Funeral Service Licensee<br><b>Nat H. Bohannon</b> M00053  |  | 22. Name and Address of Facility<br><b>Gary L. Kaufman Funeral Home at MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075</b>                            |  |  |
| Physician /Medical Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  | Approximate Interval Between Onset and Death   |
|   | Immediate Cause (Final disease or condition resulting in death)<br><b>a. Pulmonary Thromboembolism due to thrombosis of pelvic veins</b>  |  |   |  |  |
|   | Due to (or as a consequence of):  |  |   |  |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |  |  |
|   | Due to (or as a consequence of):  |  |   |  |  |
|   | Due to (or as a consequence of):  |  |   |  |  |
|   | Due to (or as a consequence of):  |  |   |  |  |
|   | <input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED  |  |   |  |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown   |  |   |  |  |
|   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  |   |  | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other: |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)   | 28b. Time of Injury   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |  |
| 29b. Signature and title of certifier<br><b>Margarita Korell</b>  |   | 29c. License number<br><b>O.C.M.E.</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>January 26, 2008</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>   |   | 32. Registrar's Signature<br><b>[Signature]</b>  |   |  |  |

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02664

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frank Taylor Scott

2. Date of Death

Month Day Year  
January 22, 2008

3. Time of Death

3:09 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince Georges

5. Social Security Number

218-56-4477

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59

8. Date of Birth

Month Day Year

8. Date of Birth

Sept. 9, 1948

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Forestville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7420 Marlboro Pike

10f. Zip Code

20747

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Marine Mechanic

16b. Kind of Business/Industry

Self-Employed

17. Father's Name (First, Middle, Last)

Donovan A. Scott

18. Mother's Name (First, Middle, Maiden Surname)

Eileen Taylor

19a. Informant's Name/Relationship (Type, Print)

Kathleen Saslaw- Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7304 Green Oak Terrace, Lanham, Maryland 20706

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

Jan. 28, 2008

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

MJB mo1234

22. Name and Address of Facility

Fleck Funeral Home, INC.  
7601 Sandy Spring Rd., Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Pulmonary Embolism

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Diabetes, Obesity, High Cholesterol

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

SOICONICWO, MD

29c. License number

D0055314

29d. Date signed (Month, Day, Year)

01-23-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYLVESTER SOICONICWO, 6192 OXON HILL RD, STE 507, OXON HILL, MD 20745

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, Ky.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02665

1- For  
State  
Registrar

|   |  |   |   |  |   |                               |   |  |  |  |                                   |  |  |  |
|---|--|---|---|--|---|-------------------------------|---|--|--|--|-----------------------------------|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Lorraine May Shomper</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>January 26, 2008</b>   |                               |   |  | 3. Time of Death<br><b>8:45 a<sup>M</sup></b>  |  |                                   |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Suburban Hospital</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>   |                               |   |  | 4c. County of Death<br><b>Montgomery</b>   |  |                                   |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>396-20-0706</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  |                               | 8. Date of Birth (Month, Day, Year)<br><b>March 26, 1924</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Wisconsin</b>   |  |                                   |  |  |  |
|   | Usual Residence of Decedent  |   |   |  |   |                               |   |  |  |  |                                   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Bethesda</b>  |                               |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                   |  |  |  |
|   | 10e. Street and Number<br><b>6323 Tone Court</b>   |   |   |  | 10f. Zip Code<br><b>20817</b>   |                               |   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |                                   |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |                               |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |                                   |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Librarian</b>   |                               |   |  | 16b. Kind of Business/Industry<br><b>Federal Government</b>  |  |                                   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Louis Meyer</b>  |   |   |  |   |                               | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mathilda Brunner</b>  |  |  |  |                                   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Dean Kenneth Shomper/Husband</b>  |   |   |  |   |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6323 Tone Court, Bethesda, MD 20817</b> |  |  |  |                                   |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc.</b>   |                               | Date<br><b>January 27, 2008</b>   |  | 20c. Location - City or Town, State<br><b>Bethesda, MD</b>   |  |                                   |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814</b>   |                               |   |  |  |  |                                   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Pulmonary Embolism</b><br>Due to (or as a consequence of):<br><b>Metastatic Lung Cancer</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>hypertension</b> |   |   |  |   |                               |   |  |  |  |                                   |  |  |  |
|   | Approximate Interval Between Onset and Death<br><b>10 Days</b>   |   |   |  |   |                               |   |  |  |  |                                   |  |  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |   |   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |                               |   |  | 23d. Date of delivery<br>Month Day Year  |  |                                   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pneumonia, malignant plural effusion</b><br><b>myocardial infarction, coagulopathy</b><br><b>hypertension</b>   |   |   |  |   |                               |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |                                   |  |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                               |   |  |  |  |                                   |  |  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                               |   |  |  |  |                                   |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |   |  | 28a. Date of Injury (Month, Day Year)   |                               | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred |  |  |  |
|   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                               |   |  |  |  |                                   |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |   |                               |   |  |  |  |                                   |  |  |  |
|   | 29b. Signature and title of certifier<br>  |   |   |  | 29c. License number<br><b>D17656</b>  |                               |   |  | 29d. Date signed (Month, Day, Year)<br><b>January 26, 2008</b>   |  |                                   |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Tipaporn Woodward M.D. 5530 Wisconsin Avenue #550 Chevy Chase, Maryland 20815</b>   |   |   |  |   |                               |   |  |  |  |                                   |  |  |  |
|   | State Registrar  | 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b> |   |  |   | 32. Registrar's Signature<br> |   |  |  |  |                                   |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760, Ky.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2008 02666

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Christopher E. Shocklee

2. Date of Death  
Month Day Year

January 27 2008

3. Time of Death

645P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

494-26-9446

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Dec. 25, 1927

9. Birthplace (State or Foreign Country)

Missouri

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Olney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16710 Gooseneck Terrace

10f. Zip Code

20832

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Information Technology Specialist

16b. Kind of Business/Industry

Computer Services

17. Father's Name (First, Middle, Last)

James Bernard Shocklee

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Hughes

19a. Informant's Name/Relationship (Type, Print)

Marilyn Margaret Cluen / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13 Valley Bend Court, Germantown, Maryland 20876

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

Feb. 2, 2008

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licenses

M00896

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.  
300 W. Montgomery Ave., Rockville, MD 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Hypoxic encephalopathy

b. Due to (or as a consequence of):

Ventricular fibrillation

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cardiogenic pulmonary arrest

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Alan S. Chavaler

29c. License number

29453

29d. Date signed (Month, Day, Year)

January 27 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan S. Chavaler 15215 Shady Grove Rd Rockville MD 20850

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02667

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

|   |   |  |   |  |  |   |  |   |  |  |
|---|---|--|---|--|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Morton Scott</b>   |  |   | 2. Date of Death<br>Month Day Year<br><b>January 26 2008</b>           |  |   | 3. Time of Death<br><b>2:40 AM</b>   |   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>VA Extended Care</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>               |  |   | 4c. County of Death  |   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-26-8735</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Mar 1, 1929</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |
|   | Usual Residence of Decedent   |  |   |  |  |   |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   |  | 10b. County   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>524 N. Charles Street</b>  |  |   |  | 10f. Zip Code<br><b>21201</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>51-54</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>black</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>self employed</b>  |   |  | 16b. Kind of Business/Industry<br><b>unk</b>                            |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Simon P. Scott</b>  |  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Frances Estella Johnson</b> |  |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Loretta Hopkins/niece</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8739 Meadow Heights Road Randallstown, MD 21133</b>                                      |   |  |   |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place) |  | Date  |  | 20c. Location - City or Town, State                                     |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>  |  |   |  | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>   |   |  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Metastatic Prostate Cancer</b><br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |   |  |   |  | Approximate Interval Between Onset and Death |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br>9 Unknown                        |  |  |   | 23d. Date of delivery<br>Month Day Year  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary Artery Disease</b>  |   |  |   |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  | 29b. Signature and title of certifier<br><b>George E. Wicks MD</b>  |  |  | 29c. License number<br><b>041365</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>January 26, 2008</b>          |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>George E. Wicks MD 3900 Loch Raven Boulevard, Baltimore, Maryland 21218</b>  |   |  |   |  |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>   |   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |   |  |   |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02668

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDRA JANENE TAFERT

2. Date of Death

January 27 2008

3. Time of Death

1110 A-M

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

WV

Funeral  
Director

5. Social Security Number

212-46-6306

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUNE 18, 1945

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3173 KESSLER RD.

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8TH

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

FACTORY WORKER

16b. Kind of Business/Industry

FACTORY

17. Father's Name (First, Middle, Last)

JACOB NETZER

18. Mother's Name (First, Middle, Maiden Surname)

EUDORA NETZER

19a. Informant's Name/Relationship (Type, Print)

ELIZABETH PHILLIPS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3173 KESSLER RD., BALTIMORE, MD 21227

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

BAYVIEW

Date

02/01/2008

20c. Location - City or Town, State

5500 O'DONNELL ST.  
BALTIMORE, MD 21224

21. Signature of Funeral Service Licensee

Wesley Chavis

22. Name and Address of Facility

WESLEY CHAVIS, JR. FNRL. HM.  
2007-09 EASTERN AVE., BALTIMORE, MD 2123123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

a. Chronic Obstructive Pulmonary Disease

Approximate  
Interval Between  
Onset and Death  
2 daysImmediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No26. Place of Death (Check only one)  
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

D.O.

29c. License number

H62862

29d. Date signed (Month, Day, Year)

January 27 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alice Tang 900 caton Ave. Baltimore, MD 21229

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No.

2008 02559

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret L. Trunk

2. Date of Death

Month Day Year  
01-27-08

3. Time of Death

4:45 A<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

214-14-9111

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
10-22-1920

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Overlea

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4508 Raspe Ave.

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

House Wife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles Gummel

18. Mother's Name (First, Middle, Maiden Surname)

Anna Clarke

19a. Informant's Name/Relationship (Type, Print)

Charles Trunk

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2602 Greene Lane Fallston MD 21047

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gardens of Faith

Date

01-31-08

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

Signature of Charles Trunk

22. Name and Address of Facility

Schimunek Funeral Home Inc.

9705 Belair Rd. Nottingham MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

CARDIAC ARREST

Approximate Interval Between Onset and Death

b. Due to (or as a consequence of):

RESPIRATORY FAILURE

minutes

c. Due to (or as a consequence of):

PNEUMONIA

1 week

d. Due to (or as a consequence of):

STROKE

2 weeks

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ARRHYTHMIA

HYPERTHYROIDISM

HBP

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Signature of Richard Carey

29c. License number

D31926

29d. Date signed (Month, Day, Year)

1/22/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAREY, RICHARD, M.D.

2300 DULANEY VALLEY ROAD

TIMONIUM MD

21093

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

Signature of Registrar

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02670

1- For State Registrar

Amend Item 21 per fh, g87602/01/08dh

Reg. No.

Physician /Medical Examiner

Funeral Director

|   |  |   |  |  |
|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>CAROL L. A. JAGGART</b>  |  | 2. Date of Death<br>Month <b>JANUARY</b> Day <b>22</b> Year <b>2008</b>   |  | 3. Time of Death<br><b>1300 PM</b>   |
| 4a. Facility Name (If not institution, give street and number)<br><b>FRANKLIN SQUARE HOSPITAL CENTER</b>  |  | 4b. City, Town, or Location of Death<br><b>ROSEDALE</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>  |
| 5. Social Security Number<br><b>218-38-3472</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>07/09/1941</b> | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |
| Usual Residence of Decedent   |  |   |  |  |
| 10a. State<br><b>MD</b>   | 10b. County  | 10c. City, Town or Location<br><b>Baltimore</b>   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
| 10e. Street and Number<br><b>1902 Sunberry Rd.</b>  |  | 10f. Zip Code<br><b>21222</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Pvt.</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Unknown</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Unknown</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Lorretto Kohlhaus/ Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1902 Sunberry Rd., Baltimore, MD 21222</b>  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Howard University Medical School</b>   |  | 20c. Location - City or Town, State<br><b>Washington, D.C.</b>   |
| 21. Signature of Funeral Service Licensee<br><b>Terry A. Austin per dvr</b>   |  | 22. Name and Address of Facility<br><b>Austin Royster Funeral Home<br/>3821 14th Street, NW., Washington, D.C. 20011</b>  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>HYPOXEMIC HYALIC RESPIRATORY FAILURE</b><br>Due to (or as a consequence of):<br>b. <b>COPD</b><br>Due to (or as a consequence of):<br>c. <b>ATRIAL FIBRILLATION</b><br>Due to (or as a consequence of):<br>d. <b>CANCER WITH METASTASIS</b> |  |   |  |  |
| 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown  |  |   |  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)   |  |   |  |  |
| 23d. Date of delivery<br>Month Day Year   |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>AP 22 MD</b>  |  | 29c. License number<br><b>062373</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>01-31-2008</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. ROBERT A. PAZ 9000 FRANKLIN SQUARE DR, BALTIMORE, MD 21237</b>   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 02671

1- For State Registrar

Physician /Medical Examiner

Funeral Director

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>James Marquis TIERNAN</b>   |  | 2. Date of Death<br>Month Day Year<br><b>January 30, 2008</b>   |   | 3. Time of Death<br>M<br><b>1:26 A</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Greater Baltimore Medical Center</b>  |  | 4b. City, Town, or Location of Death<br><b>Towson</b>   |   | 4c. County of Death<br><b>Baltimore</b>   |  |
| 5. Social Security Number<br><b>212-50-1945</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Aug 3, 1944</b> | 9. Birthplace (State or Foreign Country)<br><b>Baltimore, MD</b>  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>BALTIMORE</b>   |   | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>3997 Forest Valley Road</b>  |   | 10f. Zip Code<br><b>21234</b>   |  |
| 10g. Citizen of What Country?<br><b>USA</b>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b>  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Self-Employed</b>  |  | 16b. Kind of Business/Industry<br><b>Musician</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>Stanton Ward TIERNAN</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth Dillow</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carolyn F. Tiernan-wife</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3997 Forest Valley Rd. Baltimore, MD 21234</b>  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory, or other place)<br><b>Dillsburg Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>Dillsburg, PA</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Kimberly G. Zupotny</b>  |  | 22. Name and Address of Facility<br><b>8800 HARFORD RD. BALTIMORE MD 21234<br/>Evans Funeral Chapel + Cremation Services - Parkville</b>  |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>end stage cardiomyopathy</b>                    |  |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)                                     |   | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Ventricular tachycardia</b>   |  |   |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  |
| 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 28d. Describe how injury occurred  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Cynthia Sorian MD</b>   |   | 29c. License number<br><b>D0051347</b>  |  |
| 29d. Date signed (Month, Day, Year)<br><b>1/30/08</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Cynthia Sorian MD 6701 N. Charles St Baltimore MD 21204</b>  |   | 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>   |  |
| 32. Registrar's Signature<br><b>[Signature]</b>  |  |   |   |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Tieman, Mark  
Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, 44

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02672

1- For  
State  
Registrar

|  |  |  |   |  |   |  |   |  |  |  |  |  |
|--|--|--|---|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Phillip Wayne Tucker, Sr.</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>JAN 24 2008</b>  |  |   |  | 3. Time of Death<br><b>0138 PM</b>   |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SAINT AGNES HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  |   |  | 4c. County of Death  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-44-5256</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 28, 1944</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |  |  |
|  | Usual Residence of Decedent  |  |   |  |   |  |   |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Catonsville</b>   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |
|  | 10e. Street and Number<br><b>24 Dunvegan Road</b>  |  |   |  | 10f. Zip Code<br><b>21228</b>   |  |   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Computer Specialist</b>   |  |   |  | 16b. Kind of Business/Industry<br><b>Social Security Admin.</b>                                |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>William Earl Tucker</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lydia Johnson</b>   |  |   |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Cherie Congedo- Daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6281 Trotter Rd., Clarksville, Maryland 21029</b>   |  |   |  |  |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crem.</b>   |  |   |  | 20c. Location - City or Town, State<br><b>Jan. 30, 2008 Alexandria, Virginia</b>               |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Fleck Funeral Home, INC.<br/>7601 Sandy Spring Road, Laurel, MD 20707</b>  |  |   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>HEAD INJURY</b><br>Due to (or as a consequence of):<br>b. <b>SUB DURAL BLEED</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>UNKNOWN</b><br><b>UNKNOWN</b> |  |   |  |   |  |   |  |  |  |  |  |
|  | 23b. IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year                                       |  |   |  |   |  |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Alcohol Abuse</b>   |  |  |   |  |   |  |   |  |  |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |  |   |  |   |  |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |  |   |  |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |  |   |  |   |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |   |  |   |  |   |  |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |  |   |  |   |  |   |  |  |  |  |  |
| 28a. Date of Injury (Month, Day, Year)<br><b>Jan 16, 2008</b><br>28b. Time of Injury<br><b>UNK</b> M<br>28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>28d. Describe how injury occurred<br><b>Fall</b><br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Residence</b><br>28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>24 Dunvegan Road Catonsville, Md</b> |  |  |   |  |   |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |  |   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><br>29c. License number<br><b>P20659</b><br>29d. Date signed (Month, Day, Year)<br><b>JANUARY 28TH 2008</b>  |  |  |   |  |   |  |   |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SAINT AGNES HOSPITAL, 900 CATOWAY, BALTIMORE, MD, 21229, HAFSA KHAN</b>   |  |  |   |  |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b><br>32. Registrar's Signature<br>  |  |  |   |  |   |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0036

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Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760, 446

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02673

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dewey Thomas, Jr.

2. Date of Death

January 24, 2008

3. Time of Death

11:20 A.M.

4a. Facility Name (If not institution, give street and number)

11621 Lake Potomac Drive

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

117-28-0021

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

April 27, 1936

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11621 Lake Potomac Drive

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

1957-

1959

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Small Business Consultant

17. Father's Name (First, Middle, Last)

Dewey H. Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Annie Burrows

19a. Informant's Name/Relationship (Type, Print)

Theresa V. Brown / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11621 Lake Potomac Dr., Potomac, Maryland 20854

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven

Date

Jan. 29, 2008

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

M00896

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.

300 W. Montgomery Ave., Rockville, MD 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Colon Cancer

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
5 months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician:2 ☐ Medical Examiner:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0023600

29d. Date signed (Month, Day, Year)

January 25, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bruce Kressel, M.D., 5530 Wisconsin Ave., #1125, Chevy Chase, MD 20815

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State of Maryland / Department of Health and Mental Hygiene

Reg. No. 2008 02674

ORIGINAL



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2008 02675

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MILDRED ANN THOMPSON

2. Date of Death  
Month Day Year  
JANUARY 27, 20083. Time of Death  
2:30 P<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Tender Loving Care

4b. City, Town, or Location of Death

Edgewood

4c. County of Death

Harford

5. Social Security Number

213-30-0399

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

8. Date of Birth (Month, Day, Year)

Dec. 22, 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2519 Linwood Road

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bank Teller

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

Edward (unk) Brofka

18. Mother's Name (First, Middle, Maiden Surname)

Teresa Marie Kopczeski

19a. Informant's Name/Relationship (Type, Print)

Donna Bannon / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1701 Stephens Place, Bel Air, Maryland 21015

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp

Date

2-1-08

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

Stephen C. Neugebauer

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

Approximate Interval Between Onset and Death  
3 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

OVER 5 YEARS

c. ALZHEIMER'S DEMENTIA

OVER 5 YEARS

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

ASSISTED LIVING

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Perfecto C. Valarado

29c. License number

D00016389

29d. Date signed (Month, Day, Year)

JANUARY 28, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PERFECTO C. VALARADO M.D. 1716 HARFORD Rd Suite 105 FALLSTEN MD 21047

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

3

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02676

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Valerie Gwendolyn Tucker

2. Date of Death

Month Day Year  
JANUARY 30 2008

3. Time of Death

6:18 A M

4a. Facility Name (If not institution, give street and number)

GENESIS HAMILTON CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

224-84-5928

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

51

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

9/12/56

9. Birthplace (State or Foreign Country)

Texas

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

931 N. Luzerne Ave.

10f. Zip Code

21205

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4or 5+)

1 Year

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Support Tech

16b. Kind of Business/Industry

J.H.H

17. Father's Name (First, Middle, Last)

Walter L. Tucker

18. Mother's Name (First, Middle, Maiden Surname)

Gertrune Allen

19a. Informant's Name/Relationship (Type, Print)

Gertrune Tucker-Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1527 Piper Square #B Hopewell, VA 23860

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Mem Park

Date

2/4/08

20c. Location - City or Town, State

Randallstown, MD

21. Signature of Funeral Service Licensee

Baltimore

22. Name and Address of Facility

March F/H East  
1101 E. North Ave Baltimore, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- OBSTRUCTIVE SLEEP APNOEA

- MASS IN LIVER &amp; LYMPHADENOPATHY (IN ABDOMEN)

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Baltimore

29c. License number

D00 600 39

29d. Date signed (Month, Day, Year)

JANUARY 30 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR MAN NAIING CO, MD  
6701 NORTH CHARLES ST, SUITE 400, TOWSON, MD 21204

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

Baltimore

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02677

1- For  
State  
Registrar

|   |  |  |   |   |  |  |   |   |  |  |
|---|--|--|---|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>George Vanden, III</u>  |  |   |   | 2. Date of Death<br>Month <u>Jan</u> Day <u>30</u> Year <u>2008</u>  |  |   |   | 3. Time of Death<br><u>7:50 PM</u>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>Genesis Perrying Parkway</u>  |  |   |   | 4b. City, Town, or Location of Death<br><u>Parkville</u>   |  |   |   | 4c. County of Death<br><u>Baltimore</u>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><u>217-50-1019</u>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><u>60</u> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><u>2/13/47</u>         |   | 9. Birthplace (State or Foreign Country)<br><u>California</u>                                  |  |
|   | Usual Residence of Decedent  |  |   |   |  |  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><u>MD</u>  |  | 10b. County<br><u>BALTIMORE</u>   |   | 10c. City, Town or Location<br><u>Parkville</u>  |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><u>7507 Park Drive</u>   |  |   |   | 10f. Zip Code<br><u>21234</u>  |  | 10g. Citizen of What Country?<br><u>USA</u>                   |   |  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>white</u> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+) <u>5r</u>  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Electronic Engineer</u>  |  |   | 16b. Kind of Business/Industry<br><u>Federal Government.</u>            |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><u>George Walter Vanden, II</u>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Jean Glanville</u>   |  |   |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><u>Jean Braswell-mother</u>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>7507 Park Drive, Parkville, MD 21234</u>   |  |   |   |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Evans Funeral Chapel-Bel Air</u>                                     |   |  |  | 20c. Location - City or Town, State<br><u>Forest Hill, MD</u> |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><u>Kimberly J. Zappotny</u>   |  |   |   | 22. Name and Address of Facility<br><u>8800 Hartford Rd, Baltimore, MD 21234.</u><br><u>Evans Funeral Chapel-Cremation Services-Parkville</u>  |  |   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><u>End stage Fredrick's Ataxia</u> |  |   |   |  |  |   |   |  |  |
|   | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  |   |   |  |  |   |   |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown   |  |  |   |   |  |  |   |   |  |  |
| 23d. Date of delivery<br>Month Day Year   |  |  |   |   |  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |   |  |  |   |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |   |   |  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  |  |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |   |  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  |  |   |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |   |   |  |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |  |   |   |  |  |   |   |  |  |
| 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                    |   |   |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |  |  |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |   |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><u>Wendy Klossz</u>  |  |  |   | 29c. License number<br><u>D31295</u>  |  | 29d. Date signed (Month, Day, Year)<br><u>2/1/08</u> |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Wendy Klossz 0701 N Charles St Suite 4302 Towson MD 21204</u>  |  |  |   |   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><u>FEB 01 2008</u>   |  |  |   |   |  |  |   |   |  |  |
| 32. Registrar's Signature<br><u>[Signature]</u>   |  |  |   |   |  |  |   |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02678

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>Anne Elizabeth O'Steen Valliere  |  | 2. Date of Death<br>Month Day Year<br>January 23, 2008   |   | 3. Time of Death<br>110 P M  |  |
| 4a. Facility Name (If not institution, give street and number)<br>Holy Cross Hospital  |  | 4b. City, Town, or Location of Death<br>Silver Spring  |   | 4c. County of Death<br>Prince Georges  |  |
| 5. Social Security Number<br>577-44-1167   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>76 Yrs.  | 8. Date of Birth (Month, Day, Year)<br>December 12, 1931  | 9. Birthplace (State or Foreign Country)<br>Washington, DC   |  |
| Usual Residence of Decedent  |  |  |   |  |  |
| 10a. State<br>Maryland   | 10b. County<br>Prince Georges  | 10c. City, Town or Location<br>Laurel  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br>6415 Sandy Street  |  | 10f. Zip Code<br>20707   |   | 10g. Citizen of What Country?<br>USA   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+) 2  |   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Secretary   |  | 16b. Kind of Business/Industry<br>US Govt.   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br>Joseph Furr   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Anna May Luskey  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Pamela O'Steen-daughter  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6415 Sandy St., Laurel, Maryland 20707 |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery  |   | 20c. Location - City or Town, State<br>Silver Spring, Maryland   |  |
| 21. Signature of Funeral Service Licensee<br>Mo1234  |  | 22. Name and Address of Facility<br>Fleck Funeral Home, INC.<br>7601 Sandy Spring Rd., Laurel, MD 20707  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Recurrent Pleural Effusion<br>Due to (or as a consequence of):<br>b. Multiple Myeloma<br>Due to (or as a consequence of):<br>c. Lymphoma<br>Due to (or as a consequence of):<br>d. Sepsis |  |  |   |  | Approximate Interval Between Onset and Death   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death<br>9 <input type="checkbox"/> Unknown  |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |   |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |   |  |  |
| 29b. Signature and title of certifier<br>[Signature]   |  | 29c. License number<br>D62520  |   | 29d. Date signed (Month, Day, Year)<br>January 24, 2008  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Maria D'Arbella, 1500 Forest Glen Road, Silver Spring, Maryland 20910  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 01 2008   |  | 32. Registrar's Signature<br>[Signature]   |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend 19a, per FH G876, 2/1/08 TT Certificate of Death

Reg. No. 2008 02679

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ROBERT

WILLIAMS

2. Date of Death  
Month Day Year  
JANUARY 27 20083. Time of Death  
0525 M

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

5. Social Security Number  
220-72-40706. Sex  
☒ M ☐ F7. Age (In yrs. last birthday)  
47 Yrs.8. Date of Birth (Month, Day, Year)  
02-23-19609. Birthplace (State or Foreign Country)  
Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Harford10c. City, Town or Location  
Bel Air10d. Inside City Limits  
☐ Yes ☒ No

10e. Street and Number

1949 Cypress Drive

10f. Zip Code

21015

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced12. Was Decedent Ever in U.S. Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:14. Race - American Indian, Black, White, etc.  
Specify: White15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) College (1-4or 5+)  
216a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
Manager16b. Kind of Business/Industry  
Manufacturing Company

17. Father's Name (First, Middle, Last)

CLifton Williams

18. Mother's Name (First, Middle, Maiden Surname)

Shirley Glean

19a. Informant's Name/Relationship (Type, Print)

Rhonda K. Williams (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1949 Cypress Drive Bel Air, MD 21015

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gar.

Date

01-30-2008

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

Supremo Rucker

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd Bel Air, MD 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. EPITHELIOID HEMANGIOENDOTHELIOMA

Approximate Interval Between Onset and Death

6 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

IF FEMALE:  
23b. Was decedent pregnant in the past 12 months?  
☐ Yes ☒ No  
☐ Unknown23c. If yes, outcome of pregnancy  
☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)  
☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy performed?  
☐ Yes ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
☐ Yes ☐ No25. Was case referred to medical examiner?  
☐ Yes ☒ No26. Place of Death (Check only one)  
Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Veronique Nussenblatt, MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

JANUARY 27, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VERONIQUE NUSSENBLATT, MD 600 N. WOLFE STREET, BALTIMORE, MARYLAND 21287

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02680

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Frances Weber</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>01-27-08</b>  |  |  |  | 3. Time of Death<br><b>10:10 pM</b>  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Severna Park Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Severna Park</b>  |  |  |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>213-38-6494</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>02-22-1915</b>                             |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |  |  |
|   | Usual Residence of Decedent   |  |   |  |  |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Severn</b>   |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |
|   | 10e. Street and Number<br><b>7802 Cypress Landing Road</b>  |  |   |  | 10f. Zip Code<br><b>21144</b>  |  |  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+) <b>X-Ray Technician</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Hospital</b>   |  |  |  | 16b. Kind of Business/Industry   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Ludwig</b>  |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Barbara Matejka</b>          |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Anne Yakaitis</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7802 Cypress Landing Rd. Severn MD 21144</b>   |  |  |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bohemian National</b>  |  | Date<br><b>01/31/08</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore MD</b>                           |  |  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Schimunek Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236</b>   |  |  |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>advanced dementia</b><br>Due to (or as a consequence of):   |  |   |  |  |  |  |  |  |  |  |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of).<br>c. Due to (or as a consequence of).<br>d.  |  |   |  |  |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |   |  |  |  |  |  |  |  |  |  |
|   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)   |  |   |  |  |  |  |  |  |  |  |  |
|   | 23d. Date of delivery<br>Month Day Year   |  |   |  |  |  |  |  |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>dearrrhea</b>  |  |   |  |  |  |  |  |  |  |  |  |
|   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |  |  |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |  |  |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D50725</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>1-28-2008</b>                              |  |  |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennifer Riedinger 8001 Veterans Hwy Millersville MD 21108</b>   |  |   |  |  |  |  |  |  |  |  |  |
| State<br>Registrar                            | 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>   |  |   |  | 32. Registrar's Signature<br>  |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "nature", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02681

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Benjamin Willis, Jr.

2. Date of Death

Jan. 28, 2008

3. Time of Death

17:53 M

4a. Facility Name (If not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

231.20.2217

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

8. Date of Birth

06.14.1926

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Conowingo

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4 Woodside

10f. Zip Code

21918

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

9

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Robert Benjamin Willis, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Esther Cardwell Hicks

19a. Informant's Name/Relationship (Type, Print)

Joan Henly/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Woodside, Conowingo, MD 21918

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Cem.

Date

02.05.08

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

Lyda Sue Ritten

MO1443

22. Name and Address of Facility

Stephen Lohmann PA, CAFA 8717 Green Pasture Drive Towson MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septic shock secondary to urinary tract infection

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

48 hours

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation  
Acute renal failure  
Hyperkalemia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alfred A. Piro

29c. License number

00055190

29d. Date signed (Month, Day, Year)

January 28, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alfred A. Piro MD Union Hospital 106 Bow Street Elkton, MD

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02682

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPHINE WILLIS

2. Date of Death

01 23 2008

3. Time of Death

10:25 PM

4a. Facility Name (If not institution, give street and number)

MANORCARE NURSING CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

219-32-1636

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

9-3-1936

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTIMORE

10c. City, Town or Location

RANDALLSTOWN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3837 JANBROOK RD.

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
-12-College (1-4 or 5+)  
-4-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

BALTIMORE CITY SCHOOL

17. Father's Name (First, Middle, Last)

ALEXANDER R. BOOKER

18. Mother's Name (First, Middle, Maiden Surname)

SALLIE MCGHEE

19a. Informant's Name/Relationship (Type, Print)

LEON WILLIS (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3837 JANBROOK RD. RANDALLSTOWN, MARYLAND 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VETERANS 2-4-2008 OWINGS MILLS, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jonathan D. Hibner

Name and Address of Facility

REDD FUNERAL SERVICE  
1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTICEMIA

Due to (or as a consequence of):

b. CLOSTRIDIUM DIFFICILE COLITIS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

TYPE II DIABETES MELLITUS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

WMA M.D.

29c. License number

D0059107

29d. Date signed (Month, Day, Year)

1/30/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KALU UMA 210 BUSINESS CENTER DRIVE REISTERSTOWN MD 21136

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02683

1- For  
State  
Registrar

|  |   |  |   |  |  |
|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Hilda Zdanis</b>   |  | 2. Date of Death<br>Month Day Year<br><b>January 29, 2008</b>   |  | 3. Time of Death<br><b>11:20 A M</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>314 Heron St. Nana's Place</b>   |  | 4b. City, Town, or Location of Death<br><b>Aberdeen</b>   |  | 4c. County of Death<br><b>Harford</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-12-6844</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>09-10-1924</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  | Usual Residence of Decedent   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   | 10b. County<br><b>Harford</b>  | 10c. City, Town or Location<br><b>Aberdeen</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>314 Heron St. Nana's Place</b>   |  | 10f. Zip Code<br><b>21001</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary</b> (Secondary (0-12) <b>12</b> College (1-4or 5+))              |  |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bar Maid</b>  |  | 16b. Kind of Business/Industry<br><b>Restaurant</b>   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Edward Conklin</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edna Breed</b>  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>John E. Zdanis</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>100 Box Thorn Rd. Abingdon, MD 21009</b>      |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Baltimore National</b>   |  | 20c. Location - City or Town, State<br><b>02-01-2008 Baltimore MD</b>  |
|  | 21. Signature of Funeral Service Licensee<br><b>Stephanie Rineker</b>   |  | 22. Name and Address of Facility<br><b>Schimunek Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236</b>  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ABDOMINAL ANEURYSM RUPTURES</b><br><b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br><b>WITH HYPERTENSION</b><br><b>CEREBRAL THROMBOSIS WITH BLINDNESS</b> |  |   |  |  |
| Approximate Interval Between Onset and Death<br><b>2 HOURS</b><br><b>OVER 6 YEARS</b><br><b>OVER 6 YEARS</b><br><b>OVER 6 YEARS</b>  |   |  |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown                        |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ASSISTED LIVING</b> |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |  |
| 29b. Signature and title of certifier<br><b>Dr. J. C. Valerao</b>  |   | 29c. License number<br><b>D0016389</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>JANUARY 29, 2008</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PERFECTO C. VALERAO M.D. 1716 HARFORD RD Suite 105 FALLSTON MD 21047</b>  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>  |   | 32. Registrar's Signature<br><b>[Signature]</b>  |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 21268

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02684

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Anne V. Abt</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>January 15, 2008</b>  |  | 3. Time of Death<br><b>4:48 P M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Eden Home</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| 5. Social Security Number<br><b>063-03-2184</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>90</b>  |  | 8. Date of Birth (Month, Day, Year)<br><b>April 8, 1917</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Silver Spring</b>  |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>10705 Meadowhill Road</b>  |  | 10f. Zip Code<br><b>20901</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>2</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>   |  | 16b. Kind of Business/Industry<br><b>Public School System</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>George Voytko</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Unknown</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Janice Abt/Daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10705 Meadowhill Road, Silver Spring, MD 20901</b>   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Hope Cemetery</b>  |  | Date<br><b>Jan. 17 2008</b>  |  | 20c. Location - City or Town, State<br><b>Hastings-on-Hudson, NY</b>   |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home Inc.<br/>500 University Blvd, W., Silver Spring, MD 20901</b>  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Alzheimer's Disease</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br><b>Years</b> |  |   |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year            |  |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Group Home</b> |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D09834</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>January 16, 2008</b>   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Barry Rosenbaum, MD 3720 Farragut Avenue, Kensington, MD 20895</b>  |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 17 2008</b>  |  | 32. Registrar's Signature<br>   |  |  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02685

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |   |  |   |  |  |  |                                   |  |
|--|--|---|--|---|--|---|--|--|--|-----------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Joan C. Atkinson</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>January 16, 2008</b>   |  |   |  | 3. Time of Death<br><b>02:32 AM</b>  |  |                                   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>341 Colonial Drive</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Charlestown</b>  |  |   |  | 4c. County of Death<br><b>Cecil</b>  |  |                                   |  |
| 5. Social Security Number<br><b>172-30-3497</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>May 15, 1936</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |  |                                   |  |
| Usual Residence of Decedent  |  |   |  |   |  |   |  |  |  |                                   |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Cecil</b>   |  | 10c. City, Town or Location<br><b>Charlestown</b>   |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |                                   |  |
| 10e. Street and Number<br><b>341 Colonial Drive</b>  |  |   |  | 10f. Zip Code<br><b>21914</b>   |  |   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |                                   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |                                   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Clarence Cooper</b>  |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mildred Davidson</b>  |  |  |  |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Paul J. Atkinson, Sr./husband</b>   |  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 38 Charlestown, Maryland 21914</b> |  |  |  |                                   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mayerdale Crematory</b>  |  | Date<br><b>January 17, 2008</b>   |  | 20c. Location - City or Town, State<br><b>Newark, Delaware</b>   |  |                                   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  |   |  | 22. Name and Address of Facility<br><b>Crouch Funeral Home</b><br><b>127 South Main Street, North East, Maryland 21901</b>                      |  |  |  |                                   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Congestive Heart Failure</b><br>Due to (or as a consequence of):<br><b>b.</b> Due to (or as a consequence of):<br><b>c.</b> Due to (or as a consequence of):<br><b>d.</b> Due to (or as a consequence of): |  |   |  |   |  |   |  |  |  |                                   |  |
| Approximate Interval Between Onset and Death<br><b>years</b>   |  |   |  |   |  |   |  |  |  |                                   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  |   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown                       |  |   |  | 23d. Date of delivery<br>Month Day Year  |  |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |                                   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death Check only one<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Daughter's House</b> |  |   |  |  |  |                                   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |                                   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |  |  |                                   |  |
| 29b. Signature and title of certifier<br>  |  |   |  |   |  | 29c. License number<br><b>D 15314</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>January 16, 2008</b>   |  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>H Farkas, MD Seasons Hospice 133 N Bridge St., Elkton, MD</b>   |  |   |  |   |  |   |  |  |  |                                   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 18 2008</b>  |  |   |  | 32. Registrar's Signature<br>   |  |   |  |  |  |                                   |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02586

1- For State

Registrar

Physician/  
Medical ExaminerFuneral  
Director

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Zelma Lorraine Alder</b>  |  | 2. Date of Death<br>Month <b>January</b> Day <b>11</b> Year <b>2008</b>   |   | 3. Time of Death<br><b>1358 hrs</b>   |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Medford Rd. / Avondale Road</b>   |  | 4b. City, Town, or Location of Death<br><b>New Windsor</b>  |   | 4c. County of Death<br><b>Carroll</b>   |   |
| 5. Social Security Number<br><b>213-20-7275</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  | 8. Date of Birth (MM/DD/YYYY)<br><b>Aug 21 1922</b> | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |   |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Carroll</b>   |   | 10c. City, Town or Location<br><b>New Windsor</b>   |   |
| 10e. Street and Number<br><b>2801 Carlisle Drive</b>   |  | 10f. Zip Code<br><b>21776</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>   |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |   | 16b. Kind of Business/Industry<br><b>Own Home</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Jeremiah Mechalske</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rose Leard</b>  |   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Charles Alder III/son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>669 N. Gorsuch Road Westminster, MD 21157</b>   |   |   |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Druid Ridge Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>Pikesville, MD</b>  |   |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><b>Pritts Funeral Home and Chapel, P.A. 21157</b><br><b>412 Washington Road Westminster, MD</b>   |   |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Multiple Injuries</b><br>Immediate Cause (Final disease or condition resulting in death)<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED |  |   |   |   | Approximate Interval Between Onset and Death  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown  |  |   |   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |
| 23d. Date of delivery<br>Month Day Year  |  |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene    |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month Day Year)<br><b>Jan 11, 2008</b>   |   | 28b. Time of Injury<br><b>1350 hrs</b>  |   |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>Driver auto fixed object collision</b>  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Local Street</b>  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Medford Rd / Avondale Road, New Windsor, MD</b>   |  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |
| 29b. Signature and title of certifier<br><i>[Signature]</i><br><b>Margarita Korell MD. Assistant Medical Examiner</b>  |  | 29c. License number<br><b>O.C.M.E.</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>January 12, 2008</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>  |  | 31. Date filed (Month, Day, Year)<br><b>JAN 16 2008</b>   |   |   |   |
| 32. Registrar's Signature<br><i>[Signature]</i>  |  | 33. Registrar's Title<br><b>Registrar</b>   |   |   |   |

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 23a, pt 1 per PHYS. 6876, 2/1/08 WS

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02687

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Calliope Tsoulis Braun

2. Date of Death

January 26, 2008

3. Time of Death

10:13 A M

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

578-38-9884

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

8. Date of Birth (Month, Day, Year)

11/16/1931

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Edgewater

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1644 Fairhill Drive

10f. Zip Code

21037

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Dimitrios John Tsoulis

18. Mother's Name (First, Middle, Maiden Surname)

Chrisanthe Apostolakis

19a. Informant's Name/Relationship (Type, Print)

Bernhardt Braun/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1644 Fairhill Dr., Edgewater, MD 21037

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Kalas Crematory

Date

1/28/08

20c. Location - City or Town, State

Edgewater, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home

2973 Solomons Island Rd. Edgewater, MD 21037

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ~~Pulmonary Embolus~~  
~~Cancer of Ampulla of Vater~~

Approximate Interval Between Onset and Death

hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. **Cancer of Ampulla of Vater**

2 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D29193

29d. Date signed (Month, Day, Year)

January 28, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen Killian, MD, 3169 Braverton St, #201, Edgewater, MD 21037

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02688

1- For  
State  
Registrar

|   |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Floyd Dwight Burch</b>  |  |  |  | 2. Date of Death<br>Month <b>January</b> Day <b>18</b> , Year <b>2008</b>  |  | 3. Time of Death<br><b>20:35 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Harford Memorial Hospital</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Havre de Grace</b>  |  | 4c. County of Death<br><b>Harford</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>220-22-0249</b>  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>April 25, 1927</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Harford</b>  |  | 10c. City, Town or Location<br><b>Churchville</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>3502 Aldino Road</b>  |  | 10f. Zip Code<br><b>21028-1925</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1944-1946</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Supervisor</b>   |  | 16b. Kind of Business/Industry<br><b>Armored Guard</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Harry J. Burch</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel Kaywood</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lillian D. Burch (Wife)</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3502 Aldino Rd. Churchville, Maryland 21028-1925</b>   |  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>R.A. Ferris &amp; Co.</b>   |  | 20c. Location - City or Town, State<br><b>West Chester, PA</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Zellman Funeral Home, P.A.</b>  |  | 22. Name and Address of Facility<br><b>123 S. Washington St. Havre de Grace, MD 21078</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Gastrointestinal Bleeding</b><br>Due to (or as a consequence of):<br><b>Esophageal Varices</b><br>Due to (or as a consequence of):<br><b>End-stage Hepatic Disease</b><br>Due to (or as a consequence of):<br><b>Systemic Lupus Erythematosus</b> |  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)                      |  | 23d. Date of delivery<br>Month Day Year  |  |
|   | 23e. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Acute renal failure</b><br><b>Probable pulmonary aspiration</b>  |  | 23f. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)   |  |
|   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>David C. Brick, M.D.</b>   |  | 29c. License number<br><b>10036940</b>   |  |
|   | 29d. Date signed (Month, Day, Year)<br><b>January 20, 2008</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID C. BRICK, M.D. UNION AVENUE, HAVRE DE GRACE, MD 21078</b>   |  | 31. Date filed (Month, Day, Year)<br><b>JAN 22 2008</b>  |  | 32. Registrar's Signature<br>  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2008 02589

|   |   |  |   |  |  |  |   |   |  |  |
|---|---|--|---|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CLARA M. BELL</b>  |  |   |  |  |  | 2. Date of Death<br>Month <b>JAN</b> Day <b>20</b> Year <b>2008</b>   |   | 3. Time of Death<br><b>4:45 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>BELAIR HEALTH REHAB CENTER</b>   |  |   |  |  |  | 4b. City, Town, or Location of Death<br><b>BELAIR</b>   |   | 4c. County of Death<br><b>HARFORD</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-56-2025</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>SEP 24, 1942</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>VIRGINIA</b>  |  |
|   | Usual Residence of Decedent   |  |   |  |  |  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>HARFORD</b>   |  | 10c. City, Town or Location<br><b>HAVRE DE GRACE</b>   |  |   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>123 DEAYER STREET</b>  |  |   |  | 10f. Zip Code<br><b>21078</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>NURSES ASSISTANT</b>   |  |   | 16b. Kind of Business/Industry<br><b>HOSPITAL</b>                       |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>ROY HARRISON, SR.</b>   |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ETHEL SMITH</b>   |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>ROBERT J. BELL, SR./ HUSBAND</b>   |  |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>123 DEAYER STREET, HAVRE DE GRACE, MARYLAND 21078</b> |   |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>R.A. FERRIS &amp; CO. INC</b>   |  | Date<br><b>1/24/08</b>  |   | 20c. Location - City or Town, State<br><b>WEST CHESTER, PA</b>                                     |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Lisa Scott Colman</i>   |  |   |  |  |  | 22. Name and Address of Facility<br><b>LISA SCOTT FUNERAL HOME, P.A.<br/>552 LEWIS STREET, HAVRE DE GRACE, MARYLAND 21078</b>                             |   |  |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Metastatic Breast Cancer</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>1 year</b>     |  |   |  |  |  |   |   |  |  |
|   | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year |  |   |  |  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Anemia</b><br><b>Hypocalcemia</b>  |   |  |   |  |  |  |   |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |   |  |  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |  |  |   |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |  |   |  |  |  |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |  |   |  |  |  |   |   |  |  |
| 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |  |  |   |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i><br>29c. License number<br><b>H39022</b><br>29d. Date signed (Month, Day, Year)<br><b>January 21 2008</b>  |   |  |   |  |  |  |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert J. Bell, Sr. 1308 Business Center Way Edgewood MD 21040</b>   |   |  |   |  |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 22 2008</b><br>32. Registrar's Signature<br><i>[Signature]</i>  |   |  |   |  |  |  |   |   |  |  |

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 02690

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |  |                             |   |   |   |  |  |  |   |  |  |  |
|---|--|-----------------------------|---|---|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>John William Barclay</b>                        |                             |   |   | 2. Date of Death<br>Month <b>January</b> Day <b>20</b> Year <b>2008</b> |  |  |  | 3. Time of Death<br><b>6:55 P<sup>M</sup></b>                           |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Citizens Nursing Home</b> |                             |   |   | 4b. City, Town, or Location of Death<br><b>Harre de Grace</b>           |  |  |  | 4c. County of Death<br><b>Harford</b>                                   |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-34-2693</b>  |                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.                        |  | 8. Date of Birth<br>Month <b>July</b> Day <b>25</b> Year <b>1938</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>             |  |  |  |
|   | Usual Residence of Decedent  |                             |   |   |   |  |  |  |   |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Cecil</b> |   | 10c. City, Town or Location<br><b>Port Deposit</b>  |   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |  |
| 10e. Street and Number<br><b>30 Stayman Drive</b>   |  |                             |   | 10f. Zip Code<br><b>21904</b>   |   |  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)   |  |                             |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Sand Blaster</b>   |   |  |  | 16b. Kind of Business/Industry<br><b>Ship Building</b>   |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John William Barclay, Sr.</b>   |  |                             |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy McDougal</b>   |  |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Gladys Barclay/Wife</b>  |  |                             |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>30 Stayman Drive Port Deposit, Maryland 21904</b>  |  |  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                             |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>New Bridge Cemetery</b>  |   | Date<br><b>1-25-08</b>   |  | 20c. Location - City or Town, State<br><b>Colora, Maryland</b>                                 |   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |                             |   |   |   | 22. Name and Address of Facility<br><b>R. T. Foard Funeral Home, P.A.<br/>111 S. Queen Street Rising Sun, Maryland 21911</b>   |  |  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Chronic renal failure</b><br>Due to (or as a consequence of)<br><b>b. Cardiovascular</b><br>Due to (or as a consequence of)<br><b>c. Peripheral vascular disease status post amputation</b><br>Due to (or as a consequence of)<br><b>d. Right leg</b> |  |                             |   |   |   |  |  |  |   | Approximate Interval Between Onset and Death   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  |                             |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death<br><input type="checkbox"/> Unknown   |   |  |  | 23d. Date of delivery<br>Month Day Year  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                             |   |   |   |  |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                             |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |                             |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   | 28d. Describe how injury occurred  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |                             |   | 29b. Signature and title of certifier<br><b>H. Supgum MD</b>  |   |  |  | 29c. License number<br><b>04641</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>1/21/08</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>H. Supgum 39 S. Union Ave MD 21078</b>   |  |                             |   |   |   |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 22 2008</b>   |  |                             |   | 32. Registrar's Signature<br>   |   |  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Barclay, John W.  
Division of Vital Records, P.O. Box 68760,State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02691

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ethel Baker

2. Date of Death

Month  
1Day  
9Year  
2008

3. Time of Death

3:15 AM

4a. Facility Name (If not institution, give street and number)

12801 Columbia Pike #127

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578 22 9300

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

102 Yrs.

8. Date of Birth

8/10/1905

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12801 Old Columbia Pike #127

10f. Zip Code

20904

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cosmotologist

16b. Kind of Business/Industry

Olive Beauty Salon

17. Father's Name (First, Middle, Last)

Calvin Dickerson

18. Mother's Name (First, Middle, Maiden Surname)

Cora Howell

19a. Informant's Name/Relationship (Type, Print)

Delphea Dickerson niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12801 Old Columbia Pike #127 Silver Spring MD 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Memorial

Date

1/16/2008

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John T. Rhines Funeral Home LLC  
3005 12th St. NE Washington, DC 20017

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Month

Years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Failure To Thrive

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DC-MD 12331

29d. Date signed (Month, Day, Year)

1/11/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jack Summers 2141 K Street NW Washington, DC 20037

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02692

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Everett Eugene Burgan

2. Date of Death

Jan. 17, 2008

3. Time of Death

12:05P<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2303 Dargan School Road

4b. City, Town, or Location of Death

Sharpsburg

4c. County of Death

Washington

5. Social Security Number

218-38-1367

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 15, 1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Sharpsburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2303 Dargan School Road

10f. Zip Code

21782

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Constuction

17. Father's Name (First, Middle, Last)

Otho Lester Burgan

18. Mother's Name (First, Middle, Maiden Surname)

Hattie Virginia McCoy

19a. Informant's Name/Relationship (Type, Print)

Jason E. Burgan - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2303 Dargan School Road Sharpsburg, Maryland 21782

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mt. View Cemetery

Date

Jan. 22, 2008

20c. Location - City or Town, State

Sharpsburg, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Osborne Funeral Home, P.A.

425 S. Conococheague St. Williamsport, MD 21795

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. non small cell lung cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

4 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D46473

29d. Date signed (Month, Day, Year)

January 18, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hind Hamdan, MD; 1130 OPAL CT.; Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

JAN 23 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh 8876 2-26-08 vt

State of Maryland Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02693

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |   |  |  |  |  |  |   |  |   |  |
|---|--|---|--|---|--|--|--|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Anna Marie Beck</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>January 15, 2008</b>   |  |  |  | 3. Time of Death<br><b>9:23 P<sup>M</sup></b>  |  |   |  |   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>3810 Chaneyville Road</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Owings</b>   |  |  |  | 4c. County of Death<br><b>Calvert</b>  |  |   |  |   |  |
| 5. Social Security Number<br><b>579-18-8858</b><br><del>577-05-4901</del>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 16, 1918</b>                          |  | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>  |  |   |  |   |  |
| 10a. State<br><b>MD</b>   |  |   |  | 10b. County<br><b>Calvert County</b>  |  | 10c. City, Town or Location<br><b>Owings</b>   |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |
| 10e. Street and Number<br><b>3810 Chaneyville Road</b>  |  |   |  | 10f. Zip Code<br><b>Owings</b>  |  |  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Administrative Assistant</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Federal Government</b>  |  |   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Joesph Donohue</b>   |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Barbara McGowan</b>          |  |  |  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Barabara Stewart (Daughter)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3810 Chaneyville Road, Owings, Maryland 20736</b>   |  |  |  |  |  |   |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Olivet Cemetery</b>  |  |  |  | Date<br><b>January 22, 2008</b>  |  | 20c. Location - City or Town, State<br><b>Washington, D.C.</b>  |  |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Michael W. Lee</b>  |  |   |  | 22. Name and Address of Facility<br><b>Lee Funeral Home Calvert, P.A.<br/>8125 Southern Maryland Blvd., Owings, MD 20736</b>  |  |  |  |  |  |   |  |   |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Concurrent Heart Failure</b><br><b>Hypertension</b>  |  |   |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>6 months</b>   |  |   |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |   |  |   |  |  |  |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |   |  |   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  | 29b. Signature and title of certifier<br><b>J.M. Brooks</b>   |  |  |  | 29c. License number<br><b>839920</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>January 16, 2008</b>  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. Michael Brooks, M.D. 110 Hospital Road, Suite 111, Prince Frederick, MD</b>   |  |   |  |   |  |  |  |  |  | 20678   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 18 2008</b>   |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |  |  |   |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02694

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Artie Elizabeth Cooper

2. Date of Death

Month

Day

Year

January 28 2008

3. Time of Death

1955 M

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

220-05-0217

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

8/2/1918

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4200 Webster-Lapidum Road

10f. Zip Code

21078

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

In home

17. Father's Name (First, Middle, Last)

Cicero Ingram

18. Mother's Name (First, Middle, Maiden Surname)

Zetta Spencer

19a. Informant's Name/Relationship (Type, Print)

Linda Cooper (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4200 Webster-Lapidum Rd. Havre de Grace, MD 21078

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

R. A. Ferris &amp; Co.

Date

1/30/08

20c. Location - City or Town, State

West Chester, PA

21. Signature of Funeral Service Licensee

Kristen Angulo

22. Name and Address of Facility

Tarring-Cargo Funeral Home, P.A.  
Aberdeen, Maryland 21001-3399

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Right Hemispheric CVA

Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of)

c. Acute Renal Failure

Due to (or as a consequence of)

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Afzal, MD

29c. License number

D66102

29d. Date signed (Month, Day, Year)

01/30/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohammad Afzal, MD. 501 S UNION AVE Havre de Grace, MD. 21078

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

John B. Smith

State  
Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2008 02695

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gloria Washington Cooper

2. Date of Death

January 12 2008

3. Time of Death

1:30 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

3310 North Leisure World Blvd.

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

119-10-8041

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 18, 1916

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3310 North Leisure World Blvd

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Public Schools

17. Father's Name (First, Middle, Last)

Robert James Washington

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Kemper

19a. Informant's Name/Relationship (Type, Print)

Vernice Henry Warrick, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12903 Burleigh Street  
Upper Marlboro, MD 20774

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Georgetown University  
Medical Center

Date

January 12 2008

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Columbia Mortuary Services, P.A.  
9013 Annapolis Road, Lanham, MD 2070623a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ENDOMETRIAL CANCER

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

7 months

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D54778

29d. Date signed (Month, Day, Year)

1/16/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHERYL A. AYELSWORTH, M.D.  
2730 UNIVERSITY BLVD #400 Wheaton Md 20902

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02696

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ALDO CARLO CASTAGNETTI

2. Date of Death

January 15, 2008

3. Time of Death

8:51 AM

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

577-02-5853

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jan. 21, 1935

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14116 North Gate Drive

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Car Dealership

17. Father's Name (First, Middle, Last)

Carlo Castagnetti

18. Mother's Name (First, Middle, Maiden Surname)

Anna Ricciardi

19a. Informant's Name/Relationship (Type, Print)

Mary Ann Castagnetti (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14116 North Gate Drive Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cem.

Date

Jan. 19, 2008

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Curtis E. Day

22. Name and Address of Facility DeVol Funeral Home

10 East Deer Park Dr. Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

15 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

POLYMYOSITIS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ NoHospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John Herring MD

29c. License number

D0030414

29d. Date signed (Month, Day, Year)

JANUARY 15, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN HERRING MD 18101 PRINCE PHILIP DR OLNEY, MARYLAND 20832

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

Karen B. Sparte

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02697

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frances Edelen Cary

2. Date of Death

January 16, 2008

3. Time of Death

6:10a M

4a. Facility Name (If not institution, give street and number)

Arcola Health &amp; Rehab. Center

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-30-4401

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

97

8. Date of Birth

Feb. 17, 1910

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

1111 University Blvd., W., Apt. 317

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Clerical

17. Father's Name (First, Middle, Last)

George Edelen

18. Mother's Name (First, Middle, Maiden Surname)

Alma Hurtt

19a. Informant's Name/Relationship (Type, Print)

William Randolph Cary/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20902

1111 University Blvd. W., Apt. 317, Silver Spring,

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery

Date

January 22, 2008

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.  
500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Osteomyelitis, Cellulitis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D56691

29d. Date signed (Month, Day, Year)

1/17/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ghousia Sultana, MD 12107 Heritage Park Circle, Silver Spring, MD 20902

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Items 24a,b per dr. 8876, 02/16/08 ddb

Reg. No. 2008 02698

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Phyllis Ann Chandler</b>  |  | 2. Date of Death<br>Month <b>1</b> Day <b>9</b> Year <b>2008</b>  |  | 3. Time of Death<br><b>7:00 a M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Seasons Hospice</b>   |  | 4b. City, Town, or Location of Death<br><b>Savage</b>   |  | 4c. County of Death<br><b>Howard</b>   |  |
| 5. Social Security Number<br><b>223-30-4292</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>5/18/1930</b>  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Prince George's</b>                                      | 10c. City, Town or Location<br><b>Berwyn Heights</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>8810 Edmonston Rd.</b>  |  | 10f. Zip Code<br><b>20740</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Executive Administrative Asst</b>  |  | 16b. Kind of Business/Industry<br><b>University of Maryland College Park</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Lawrence Hagee</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Fayette Pulliam</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John Chandler, Husband</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8810 Edmonston Rd., Berwyn Heights, MD 20740</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>1/12/2008 Brentwood, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>Ernest A. Colvin II</b>  |  | 22. Name and Address of Facility<br><b>Gasch's FUNeral Home, P.A. 4739 Baltimore Ave. Hyattsville, MD 20782</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>UREMIA</b><br>a. Due to (or as a consequence of):<br><b>DIABETIC NEPHROPATHY</b><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |  |  |
| 23b. IF FEMALE:<br>Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown             |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>A.L.F.</b> |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation<br>6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Arvin Deia</b>   |  | 29c. License number<br><b>MD D0063145</b>   |  | 29d. Date signed (Month/Day, Year)<br><b>1/11/08</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ARVIN DEIA 705 DIGITAL DRIVE LINTHAI CON</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 17 2008</b>  |  | 32. Registrar's Signature<br><b>Kevin H. Spiller</b>  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02699

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George Robert Carr

2. Date of Death

Month Day Year  
January 8<sup>th</sup> 2008

3. Time of Death

00:05 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Union Hospital of Cecil County

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

5. Social Security Number

161-14-3268

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

8. Date of Birth (Month, Day, Year)

June 22, 1919

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

North East

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

47 Sunset Drive

10f. Zip Code

21901

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1941-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner/President

16b. Kind of Business/Industry

Milk Transportation

17. Father's Name (First, Middle, Last)

Robert H. Carr

18. Mother's Name (First, Middle, Maiden Surname)

Edith Duling

19a. Informant's Name/Relationship (Type, Print)

Ida Mae Carr / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

47 Sunset Drive, North East, Maryland 21901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

North East Methodist

Date

January 12, 2008

20c. Location - City or Town, State

North East, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Crouch Funeral Home

127 South Main Street, North East, Maryland 21901

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Tension Pneumothorax

hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0053309

29d. Date signed (Month, Day, Year)

January 8<sup>th</sup>, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Union Hospital, Elkton MD 21921

31. Date filed (Month, Day, Year)

JAN 11 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02700

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jennie Carter

2. Date of Death

January 12, 2008

3. Time of Death

8:10 p M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Doctor's Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

PG

5. Social Security Number

223-40-2658

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

8. Date of Birth

03/10/1918

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

PG

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12849 Holiday Lane

10f. Zip Code

20716

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
4th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Self employed

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Carter

19a. Informant's Name/Relationship (Type, Print)

Sharon Johnson - Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12849 Holiday Lane; Bowie, Maryland 20716

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Cemetery

Date

01/18/2008

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

J. Freeman

22. Name and Address of Facility

Freeman Funeral Services

4594 Beech Road; Temple Hills, MD 20748

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

72 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senility; Obstipation

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

S. J. Rao

29c. License number

D-3U525

29d. Date signed (Month, Day, Year)

January 14, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. J. Rao, Md, 4000 Mitchellville Road, Suite 220; Bowie, MD 20716

31. Date filed (Month, Day, Year)

JAN 18 2008

32. Registrar's Signature

J. Rao

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
1- For State Amend 28b, 28d, & 28e, per ME, 877 3/4/08 TT  
Registrar

## Certificate of Death

Reg. No.

2008 02701

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Chester Alverne Clark

2. Date of Death

January 13, 2008

3. Time of Death

9:20 A<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

4100 Accokeek Road

4b. City, Town, or Location of Death

Brandywine

4c. County of Death

Prince George's

5. Social Security Number

217-46-7757

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

8. Date of Birth (Month, Day, Year)

Oct. 13, 1945

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Prince George's

10c. City, Town or Location

Brandywine

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4100 Accokeek Road

10f. Zip Code

20613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1965-1967

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter/Home Builder

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Chester Arthur Clark

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Winifred O'Neill Clark

19a. Informant's Name/Relationship (Type, Print)

Shannon Sopata/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3521 River Bridge Way, Laurel, Maryland 20724

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Huntt Crematory

Date

01/15/2008

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

Jack Wilgus

MO1246

22. Name and Address of Facility

3035 Old Washington Road  
Huntt Funeral Home Waldorf, Maryland 20601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gunshot Wound to Head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death  
5 ☐ Other (Specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

January 13, 2008

28b. Time of injury

9:50 A<sup>M</sup>

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject shot himself in the head

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  
Driveway home28f. Location (Street and Number or Rural Route Number, City or Town, State)  
4100 Accokeek Road, Prince George's, Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Salvador Sylvester

29c. License number

H0053927

29d. Date signed (Month, Day, Year)

January 15, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador Sylvester 3001 Hospital Drive, Chevy Chase, Maryland

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

Kiana H. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 must be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02702

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Virdell Cooper

2. Date of Death

January 15, 2008

3. Time of Death

7:00 P. M

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

251-58-1633

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
08/20/38

9. Birthplace (State or Foreign Country)

Folkston, Ga.

Usual Residence of Decedent

10a. State

Md.

10b. County

P.G.

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6922 Decatur Place

10f. Zip Code

20784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify: African-  
American15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Meat Selector

16b. Kind of Business/Industry

Safeway Warehouse

17. Father's Name (First, Middle, Last)

Anderson Cooper

18. Mother's Name (First, Middle, Maiden Surname)

Lillie Maude Williams

19a. Informant's Name/Relationship (Type, Print)

Vera M. Cooper/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6922 Decatur Place, Hyattsville, Md. 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Ft. Lincoln Cem.

Date

01/22/08

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

H.S. Washington & Sons Co., Inc.  
4925 Burroughs Ave., N.E., Washington, D.C. 2001923a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. James Cateveno 3001 Hospital Drive Cheverly MD 20785

31. Date filed (Month, Day, Year)

JAN 18 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02703

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Steven E. Duty Sr.

2. Date of Death

January 15, 2008

3. Time of Death

6:20 a M

4a. Facility Name (If not institution, give street and number)

504 Susquehanna Avenue

4b. City, Town, or Location of Death

Perryville

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

216-74-1743

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

49

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 12, 1958

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Perryville

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

504 Susquehanna Avenue

10f. Zip Code

21903

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 Yes 2 No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 Yes 2 No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
Twelve Years

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Lafon Trucking  
Abingdon, Maryland

17. Father's Name (First, Middle, Last)

Muncy Duth

18. Mother's Name (First, Middle, Maiden Surname)

Jean M. Hannigan

19a. Informant's Name/Relationship (Type, Print)

Margaret A. Duty (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

504 Susquehanna Avenue, Perryville, Maryland 21903

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

R.A. Ferris &amp; Co., Inc.

Date

01/20/08

20c. Location - City or Town, State

West Chester, Pennsylvania

21. Signature of Funeral Service Licensee

James M. Patterson Sr.

22. Name and Address of Facility

Lee A. Patterson & Son Funeral Home, P.A.  
Perryville, Maryland 21903-076623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Chronic obstructive Pulmonary Disease years.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 Yes 2 No  
9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy  
4 Pregnant at time of death 5 Other (specify)  
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an  
autopsy  
performed?  
1 Yes 2 No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 Yes 2 No25. Was case referred to medical  
examiner?  
1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DCA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending  
2 Accident investigation  
3 Suicide 6 Could not be  
4 Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Joshua N. Aaron MD

29c. License number

D0847471

29d. Date signed (Month, Day, Year)

January 16 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joshua N Aaron, MD Suite 101 111 West High Street Elkton Maryland 21921

31. Date filed (Month, Day, Year)

JAN 22 2008

32. Registrar's Signature

Kenna B. Spill

State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02704

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ann Burke Buzzerd Dicken

2. Date of Death

Month 1 Day 17 Year 2008

3. Time of Death

10:20 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

12631 Whisper Trace Dr.

4b. City, Town, or Location of Death

Ocean City

4c. County of Death

Worcester

5. Social Security Number

217-28-9225

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

8. Date of Birth

12/25/1931

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Ocean City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12631 Whisper Trace Dr.

10f. Zip Code

21842

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles Buzzerd

18. Mother's Name (First, Middle, Maiden Surname)

Helena Burke

19a. Informant's Name/Relationship (Type, Print)

Robert S. Dicken / husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12631 Whisper Trace Dr., Ocean City, MD 21842

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cape Henlopen Crem.

Date

1/21/2008

20c. Location - City or Town, State

Frankford, DE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

The Burbage Funeral Home  
108 William St., Berlin, MD 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

b. CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D46257

29d. Date signed (Month, Day, Year)

1/17/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDWIN CARSTEN A MD 10324 OLD OCEAN CITY BLVD. BERLIN, MD 21811

31. Date filed (Month, Day, Year)

JAN 18 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

BA 12

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02705

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Debra Parham Datcher

2. Date of Death

January 16, 2008

3. Time of Death

12:09A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

212-54-2666

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 16, 1950

9. Birthplace (State or Foreign Country)

Wash., DC

Usual Residence of Decedent

10a. State

Md.

10b. County

PG

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5320 West Boniwood Turn

10f. Zip Code

20735

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrative Director

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Charles Parham Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Helen Butler

19a. Informant's Name/Relationship (Type, Print)

Andrea Datcher/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4370 Big Horn Pass  
Douglasville, GA 30135

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cem.

Date

1/23/08

20c. Location - City or Town, State

Clinton, Md.

21. Signature of Funeral Service Licensee

Joanna Hodges

22. Name and Address of Facility

Hodges & Edwards F.H.  
3910 Silver Hill Rd., Suitland, Md. 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septicemia  
Due to (or as a consequence of):b. Bacterial pneumonia  
Due to (or as a consequence of):c. Diffuse metastasis  
Due to (or as a consequence of):d. malignant melanoma  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

2 days

unknown

unknown

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

V. Korman MD

29c. License number

D63183

29d. Date signed (Month, Day, Year)

1/16/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIJAY SARI KANNAN, 7503 CORRAINS ROAD, CLINTON - MD 20735

31. Date filed (Month, Day, Year)

JAN 18 2008

32. Registrar's Signature

Bram D. Spaulding

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02706

1- For  
State  
Registrar

|                                     |   |   |   |  |   |   |   |  |  |  |                                   |  |
|-------------------------------------|---|---|---|--|---|---|---|--|--|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Beatrice Laura Dennis</b>  |   |   |  | 2. Date of Death<br>Month <b>01</b> Day <b>15</b> Year <b>2008</b>  |   |   |  | 3. Time of Death<br><b>11:28 A M</b>   |  |                                   |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>Peninsula Regional Medical Center</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Salisbury, MD</b>  |   |   |  | 4c. County of Death<br><b>Wicomico</b>   |  |                                   |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>213-24-1587</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 28, 1926</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |                                   |  |
|                                     | Usual Residence of Decedent   |   |   |  |   |   |   |  |  |  |                                   |  |
| To Be Completed by Funeral Director | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Worcester</b>   |  | 10c. City, Town or Location<br><b>Newark</b>  |   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                   |  |
|                                     | 10e. Street and Number<br><b>6755 Basket Switch Road</b>  |   |   |  | 10f. Zip Code<br><b>21841</b>   |   |   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |                                   |  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |                                   |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4or 5+) <b>laborer</b>  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>laborer</b>   |   |   |  | 16b. Kind of Business/Industry<br><b>Poultry Industry</b>  |  |                                   |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Clarence Tingle</b>   |   |   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Johnson</b>   |  |  |  |                                   |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Alfreda Dennis-Bowyer/daughter</b>   |   |   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>129 Conley Drive, Chestertown, MD 21620</b> |  |  |  |                                   |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Wesley UMC Cem.</b>  |   |   |  | 20c. Location - City or Town, State<br><b>01/26/2008 Snow Hill, Maryland</b>   |  |                                   |  |
|                                     | 21. Signature of Funeral Service Licensee<br><i>Alfreda A. Jolley</i>   |   |   |  | 22. Name and Address of Facility<br><b>1213 Jersey Road, Salisbury, MD<br/>JOLLEY MEMORIAL CHAPEL, P.A. 21801</b>   |   |   |  |  |  |                                   |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Congestive Heart Failure</b><br>Due to (or as a consequence of):<br><b>Cardiomyopathy</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):     |   |   |  |   |   |   |  |  |  |                                   |  |
|                                     | 23b. Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   |   |  |   |   |   |  |  |  |                                   |  |
| Physician<br>/Medical<br>Examiner   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |   |   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   |   |  | 23d. Date of delivery<br>Month Day Year  |  |                                   |  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Sepsis</b><br><b>Acute Renal Failure</b><br><b>Diabetes</b>  |   |   |  |   |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |                                   |  |
|                                     | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |  |  |                                   |  |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |  |                                   |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   |   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred |  |
|                                     | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |  |  |                                   |  |
|                                     | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |   |   |   |  |  |  |                                   |  |
|                                     | 29b. Signature and title of certifier<br><i>[Signature]</i> MD.   |   |   |  | 29c. License number<br><b>D34768</b>  |   |   |  | 29d. Date signed (Month, Day, Year)<br><b>1/16/07</b>  |  |                                   |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. Wieland, M.D. P.R.M.C. 100 E. Carroll St. Salisbury, MD.</b>  |   |   |  |   |   |   |  |  |  |                                   |  |
|                                     | State<br>Registrar  | 31. Date filed (Month, Day, Year)<br><b>JAN 18 2008</b> |   |  |   | 32. Registrar's Signature<br><i>[Signature]</i> |   |  |  |  |                                   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2008 02707

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Woodrow Fleming

2. Date of Death

Month Day Year  
Jan. 12, 2008

3. Time of Death

2:30 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

579-60-7216

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
7/31/1916

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

DC

10b. County

N/A

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

726 Quebec St., N.W.

10f. Zip Code

20010

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assistant Principal

16b. Kind of Business/Industry

D.C. Public School

17. Father's Name (First, Middle, Last)

William F. Fleming

18. Mother's Name (First, Middle, Maiden Surname)

Lula Lillie Lee McKelley

19a. Informant's Name/Relationship (Type, Print)

Lula Mundy Sanderlin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

327 Longfellow St., N.W. Wash. D.C. 20011

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Mem. Cem.

Date

1/18/08

20c. Location - City or Town, State

Suitland, MD

21. Signature of Funeral Service Licensee

Andre Thompson

22. Name and Address of Facility

McGuire Funeral Service, Inc

7400 Georgia Ave., N.W. Wash. D.C. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Drewry J. White MD

29c. License number

57692

29d. Date signed (Month, Day, Year)

Jan. 14, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. DREWRY J. WHITE, 7600 CARROLL AVE. TAKOMA PARK, MD. 20912

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

Debra B. [Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amended # 20b Per FH, 1/17/08 Certificate of Death

Reg. No. 2008 02708

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alphonso Wayne Felton

2. Date of Death

Month

Day

Year

3. Time of Death

3:20 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince Georges

5. Social Security Number

246 96 3007

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50 Yrs.

8. Date of Birth

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

6-7-1957

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5703 Newton Street

10f. Zip Code

20784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Nautical Cartographic Analyst

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Willie S. Felton

18. Mother's Name (First, Middle, Maiden Surname)

Annie Brown

19a. Informant's Name/Relationship (Type, Print)

Rev. John W. Felton / Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

339 Paxton Street, Elizabeth City, NC 27909

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

New Oak Grove

Date

2/21/2008

20c. Location - City or Town, State

Elizabeth City - NC

21. Signature of Funeral Service Licensee

Nelson

22. Name and Address of Facility

Greene Funeral Home

814 Franklin Street, Alexandria, VA 22314

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. AIDS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

1/11/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Terry Math

Boon Hosp Dr Cheverly and 20785

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

James D. Spivey

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2008 02709

1- For State Registrar

Reg. No.

|   |  |  |   |  |  |   |
|---|--|--|---|--|--|---|
| Physician/<br>Medical Examiner                | 1. Decedent's Name (First, Middle, Last)<br><b>Brad Alan Fowler</b>  |  | 2. Date of Death<br>Month Day Year<br><b>January 16, 2008</b>   |  | 3. Time of Death<br><b>2115 hrs</b>  |   |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Rt. 231 at Yardley Drive</b>  |  | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>   |  | 4c. County of Death<br><b>Calvert</b>  |   |
| Funeral Director                              | 5. Social Security Number<br><b>215-13-7632</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>21</b> Yrs.  | 8. Date of Birth (MM/DD/YYYY)<br><b>11/16/1986</b> |  | 9. Birthplace (State or Foreign Country) <b>MD</b>  |
|   | Usual Residence of Decedent  |  |   |  |  |   |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>  | 10b. County<br><b>Calvert</b>  | 10c. City, Town or Location<br><b>Lusby</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
|   | 10e. Street and Number<br><b>865 Camp Conoy Road</b>   |  | 10f. Zip Code<br><b>20657</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |   |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: |   |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>Unemployed</b>  |  |  |   |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Did not work</b>   |  | 16b. Kind of Business/Industry  |  |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Gerald Ted Fowler</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Brenda Joyce Spaid</b>  |  |  |   |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Brenda Fowler (Mother)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>865 Camp Conoy Road, Lusby, Maryland 20657</b>  |  |  |   |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other Specify:   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | 20c. Location - City or Town, State<br><b>1/18/08 Alexandria, Virginia</b>   |   |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>Sh. S. Smith</i>   |  | 22. Name and Address of Facility<br><b>Rausch Funeral Home, P.A.<br/>P. O. Box 600, Lusby, Maryland 20657</b>   |  |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) a. <b>Multiple Injuries</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):<br><input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED |  |   |  |  | Approximate Interval Between Onset and Death  |
| To Be Completed by Physician/Medical Examiner | 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  |   |  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |
|   | 23d. Date of delivery<br>Month Day Year  |  |   |  |  |   |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |
|   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other: Scene |  |  |   |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>Jan 16, 2008</b>   |  | 28b. Time of Injury<br><b>2108 hrs</b>   |   |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>Driver auto fixed object collision and ejected</b>  |  |  |   |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Major Road / Highway</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Rt. 231 &amp; Yardley Drive, Prince Frederick, Md.</b>   |  |  |   |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  | 29b. Signature and title of certifier<br><i>Ling Li, MD</i>   |
|   | 29c. License number<br><b>O.C.M.E.</b>   |  |   |  |  | 29d. Date signed (Month, Day, Year)<br><b>January 17, 2008</b>  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a)<br><b>Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>   |  |   |  |  |   |
|   | 31. Date filed (Month, Day, Year)<br><b>JAN 18 2008</b>  |  |   |  |  | 32. Registrar's Signature<br><i>Sharon A. Spaid</i>   |

Baltimore, MD 21215-0036  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Division of Vital Records, P.O. Box 68760,  
Baltimore, MD 21215-0036  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02710

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bessie Irene Getzandanner

2. Date of Death

January 27 2008

3. Time of Death

3:10P M

4a. Facility Name (If not institution, give street and number)

Glade Valley Nursing &amp; Rehab. Ctr.

4b. City, Town, or Location of Death

Walkersville

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

217-10-0344

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth (Month, Day, Year)

July 15, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Thurmont

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8216 Rocky Ridge Rd.

10f. Zip Code

21788

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

laboratory technician

16b. Kind of Business/Industry

research

17. Father's Name (First, Middle, Last)

John Tyson Tregoning

18. Mother's Name (First, Middle, Maiden Surname)

Nora Mercer

19a. Informant's Name/Relationship (Type, Print)

N. Wayne Getzandanner/stepson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8214 Rocky Ridge Rd. Thurmont, MD 21788

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

McKaig Cemetery

Date

1/31/2008

20c. Location - City or Town, State

nr. Mt. Pleasant, MD

21. Signature of Funeral Service Licensee

*Catherine O. Harbler*

22. Name and Address of Facility

Hartzler Funeral Home  
11802 Liberty Rd. Libertytown, MD 21762

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Sequentially list conditions, starting with the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

2 wks

2 wks

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Urinary tract infection  
Dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician:2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Allen J. Gilson*

29c. License number

D 26 S16

29d. Date signed (Month, Day, Year)

JAN 28 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALLEN J GILSON

1475 TANEY AVE

FRED MD 21702

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

*Allen J. Gilson*

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 44

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02711

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Erma I. Gladfelter

2. Date of Death

January 19, 2008

3. Time of Death

6:00 P<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Citizens Nursing Home

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

5. Social Security Number

192-32-2864

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

8. Date of Birth

Nov. 23, 1915

9. Birthplace (State or Foreign Country)

Windsor Twp, PA

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

415 S. Market St.

10f. Zip Code

21078

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

teacher

16b. Kind of Business/Industry

education

17. Father's Name (First, Middle, Last)

Alvin G. Strayer

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Waughtel

19a. Informant's Name/Relationship (Type, Print)

Philip E. Gladfelter / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4047 Wilkinson Rd. Havre de Grace, MD 21078

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bethlehem Stonepile UM Church Cemetery

Date

1/24/2008

20c. Location - City or Town, State

Red Lion, PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burg Funeral Home, Inc 134 W. Broadway Red Lion PA 17356

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. coronary artery disease

Due to (or as a consequence of):

b. hypertension

Due to (or as a consequence of):

c. anemia

Due to (or as a consequence of):

d. pulmonary embolism

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

History of ulcers on status post resection  
hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Philip E. Gladfelter

29c. License number

D46412

29d. Date signed (Month, Day, Year)

1/21/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip E. Gladfelter 319 S. Union Ave MD 21078

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02712

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

KENNETH MELVIN GLENN, SR.

2. Date of Death

JANUARY 28 2008

3. Time of Death

7:45 p<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

21284 Chesapeake Ave.

4b. City, Town, or Location of Death

Rock Hall

4c. County of Death

Kent

5. Social Security Number

214-32-5714

6. Sex

1<sup>M</sup> 2<sup>F</sup>

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 9 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Kent

10c. City, Town or Location

Rock Hall

10d. Inside City Limits

1<sup>Yes</sup> 2<sup>No</sup>

10e. Street and Number

21284 Chesapeake Ave.

10f. Zip Code

21661

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1<sup>Never Married</sup> 2<sup>Married</sup>3<sup>Widowed</sup> 4<sup>Divorced</sup>

12. Was Decedent Ever in U.S.

Armed Forces?

1<sup>Yes</sup> 2<sup>No</sup>

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1<sup>Yes</sup> 2<sup>No</sup> Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Groundskeeper

16b. Kind of Business/Industry

Farm

17. Father's Name (First, Middle, Last)

Melvin Leon Glenn

18. Mother's Name (First, Middle, Maiden Surname)

Mary S. Kelly

19a. Informant's Name/Relationship (Type, Print)

Kenneth M. Glenn, Jr. (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21290 Chesapeake Ave. Rock Hall, MD. 21661

20a. Method of Disposition

1<sup>Burial</sup> 2<sup>Cremation</sup> 3<sup>Removal from State</sup>4<sup>Donation</sup> 5<sup>Other (Specify)</sup>

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Kent Cremation

Date

1/29/08

20c. Location - City or Town, State

Smyrna, DE.

21. Signature of Funeral Service Licensee

M00510

22. Name and Address of Facility

Galena Funeral Home of Stephen L. Schaech

118 West Cross St. Galena, MD. 21635

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Invasive Papillary Squamous Cell

Due to (or as a consequence of):

Carcinoma of Pharynx

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1<sup>Yes</sup> 2<sup>No</sup>3<sup>Unknown</sup>

23c. If yes, outcome of pregnancy

1<sup>Live birth</sup> 2<sup>Fetal death</sup>3<sup>Ectopic pregnancy</sup>4<sup>Pregnant at time of death</sup>5<sup>Other (Specify)</sup>

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1<sup>Yes</sup> 2<sup>No</sup> 3<sup>Probably</sup> 4<sup>Unknown</sup>

24a. Was an

autopsy

performed?

1<sup>Yes</sup> 2<sup>No</sup>

24b. Were autopsy findings available

prior to completion of cause of

death?

1<sup>Yes</sup> 2<sup>No</sup>

25. Was case referred to medical

examiner?

1<sup>Yes</sup> 2<sup>No</sup>

26. Place of Death (Check only one)

Hospital:

1<sup>Inpatient</sup>2<sup>ER/Outpatient</sup>3<sup>DOA</sup>

Other:

4<sup>Nursing Home</sup>5<sup>Residence</sup>6<sup>Other (Specify)</sup>

27. Manner of Death

1<sup>Natural</sup>2<sup>Accident</sup>3<sup>Suicide</sup>4<sup>Homicide</sup>5<sup>Pending investigation</sup>6<sup>Could not be determined</sup>

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1<sup>Yes</sup> 2<sup>No</sup>

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1<sup>Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</sup>2<sup>Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</sup>

29b. Signature and title of certifier

29c. License number

D001703C

29d. Date signed (Month, Day, Year)

1/29/08

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Susan K. Ross, M.D. 516 Washington Ave. Chestertown, MD. 21620

31. Date filed (Month, Day, Year)

32. Registrar's Signature

FEB 01 2008

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 44

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar


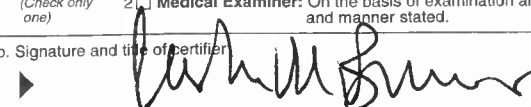

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02713

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Dorcas Teal Glasgow</b>   |  | 2. Date of Death<br>Month Day Year<br><b>1/12/2008</b>  |  | 3. Time of Death<br><b>5:30 P<sup>M</sup></b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>4116 Hamilton Street</b>  |  | 4b. City, Town, or Location of Death<br><b>Hyattsville</b>  |  | 4c. County of Death<br><b>Prince George's</b>  |  |
| 5. Social Security Number<br><b>216-40-6329</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>6/3/1916</b>                           | 9. Birthplace (State or Foreign Country)<br><b>Hyattsville, MD</b>   |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Prince George's</b>  | 10c. City, Town or Location<br><b>Hyattsville</b>   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>4116 Hamilton Street</b>  |  | 10f. Zip Code<br><b>20781</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>4</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>   |  | 16b. Kind of Business/Industry<br><b>Prince George's County Public Schools</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Eli Bennett Teal</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rosalia Augusta King</b> |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dorcas Glasgow Zoller, Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11696 Carroll Mill Rd., Ellicott City, MD 21042</b>   |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | 20c. Location - City or Town, State<br><b>1/17/2008 Alexandria, VA</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Gasch's Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, MD 20781</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><b>Alzheimer's Disease</b>  |  |   |  |  |  |
| Due to (or as a consequence of):   |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |  |  |
| Due to (or as a consequence of):   |  |   |  |  |  |
| Due to (or as a consequence of):   |  |   |  |  |  |
| Due to (or as a consequence of):   |  |   |  |  |  |
| IF FEMALE:   |  |   |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death<br>9 <input type="checkbox"/> Unknown   |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death Check only one<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D0031563</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>January 15, 2008</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Charles M. Benner, MD 10801 Lockwood Dr. # 205, Silver Spring, MD 20901</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 17 2008</b>  |  | 32. Registrar's Signature<br>  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

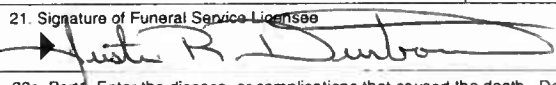
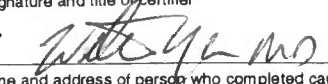
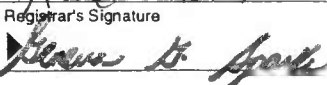
State of Maryland / Department of Health and Mental Hygiene

2008 02714

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Norman Sterling Gesell   |   | 2. Date of Death<br>Month Day Year<br>January 13, 2008   |  | 3. Time of Death<br>8:20 p M  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Carroll Lutheran Village Health Care Center  |   | 4b. City, Town, or Location of Death<br>Westminster  |  | 4c. County of Death<br>Carroll  |
| Funeral<br>Director   | 5. Social Security Number<br>219-18-2619   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>84 Yrs.  | 8. Date of Birth (Month, Day, Year)<br>Jun 3, 1923   | 9. Birthplace (State or Foreign Country)<br>Maryland  |
|   | Usual Residence of Decedent  |   |  |  |   |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   | 10b. County<br>Carroll  | 10c. City, Town or Location<br>Westminster   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|   | 10e. Street and Number<br>1200 Long Valley Road  |   | 10f. Zip Code<br>21158   |  | 10g. Citizen of What Country?<br>USA  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: white   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)                                       |  |   |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Shipping/Receiving  |   | 16b. Kind of Business/Industry<br>Manufacturing  |  |   |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br>John Henry Gesell   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Blanche Eva Autz  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Dr. Carol G. Dorsey, daughter  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1200 Long Valley Road, Westminster, MD 21158              |  |   |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>South Carroll Crematory  |  | 20c. Location - City or Town, State<br>1/15/2008 Winfield, MD   |
|   | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br>Myers-Durboraw Funeral Home<br>91 Willis Street, Westminster, MD 21157   |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cerebrovascular Accident<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br>Months |   |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |   |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br>D0058137   |  | 29d. Date signed (Month, Day, Year)<br>1/14/08   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Wilbur Kue 295 Gtuner Ave St 307 Westminste MD 21157  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br>JAN 15 2008  |  | 32. Registrar's Signature<br>  |  |  |   |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02715

1- For  
State  
Registrar

|   |  |  |   |   |  |  |   |   |  |  |  |   |   |  |  |
|---|--|--|---|---|--|--|---|---|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Maurice Wanner Graham</b>   |  |   | 2. Date of Death<br>Month <b>01</b> Day <b>15</b> Year <b>2008</b>                                      |  |  | 3. Time of Death<br><b>0529 A M</b>         |   |  |  |  |   |   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Peninsula Regional Medical Center</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Salisbury</b>  |  |  | 4c. County of Death<br><b>Wicomico</b>      |   |  |  |  |   |   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-18-4357</b>  |  |   | 6. Sex<br><b>1 M 2 F</b>  |  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.                           |   | 8. Date of Birth (Month, Day, Year)<br><b>9/16/1917</b>                 |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |   |  |  |
|   | Usual Residence of Decedent  |  |   |   |  |  |   |   |  |  |  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Wicomico</b>  |   | 10c. City, Town or Location<br><b>Salisbury</b>  |  |   |   | 10d. Inside City Limits<br><b>1 Yes 2 No</b> |  |  |   |   |  |  |
|   | 10e. Street and Number<br><b>139 Onley Road</b>  |  |   |   | 10f. Zip Code<br><b>21804</b>  |  | 10g. Citizen of What Country?<br><b>USA</b> |   |  |  |  |   |   |  |  |
|   | 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b><br>If Yes, Give Year or Dates: <b>Army</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No</b> Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |  |  |   |   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b>   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>senior shipping clerk</b>  |  |   | 16b. Kind of Business/Industry<br><b>pump manufacturing</b>             |  |  |  |   |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Alvin Peter Graham</b>   |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Anderson</b> |   |   |  |  |  |   |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Emma F. Graham/wife</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>139 Onley Rd., Salisbury, MD 21804</b> |  |   |   |  |  |  |   |   |  |  |
|   | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b><br><b>Entombment</b>   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Wicomico Memorial Park</b> |  | Date<br><b>1/18/08</b>   |   | 20c. Location - City or Town, State<br><b>Salisbury, MD</b>             |  |  |  |   |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br><b>Holloway Funeral Home Professional Association<br/>501 Snow Hill Rd., Salisbury, MD 21804</b>       |  |   |   |  |  |  |   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Myocardial Infarction</b><br>Due to (or as a consequence of):<br><b>Circulatory Artery Disease</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  |   |   |  |  |   |   |  |  | Approximate Interval Between Onset and Death   |   |   |  |  |
|   | 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br><b>1 Yes 2 No 9 Unknown</b>  |  |   |   |  |  |   |   |  |  | 23c. If yes, outcome of pregnancy<br><b>1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown</b> |   | 23d. Date of delivery<br>Month Day Year |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Arteriosclerosis</b>   |  |  |   |   |  |  |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>   |  | 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b> |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b> |  |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |  |  |   |   |  |  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |   |   |  |  |
| 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>   |  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><b>1 Yes 2 No</b>   |   | 28d. Describe how injury occurred            |  |  |   |   |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                |   |  |  |   |   |  |  |  |   |   |  |  |
| 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |  |   |   |  |  |   |   |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>040715</b>                |   | 29d. Date signed (Month, Day, Year)<br><b>1/15/08</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Steven Hearne, MD P.R.M.C. 100 E. Carroll St. Salisbury, MD 21804</b>  |  |  |   |   |  |  |   |   |  | 31. Date filed (Month, Day, Year)<br><b>JAN 16 2008</b>  |  | 32. Registrar's Signature<br>                       |   |  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02716

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Edward Griffin

2. Date of Death

January 13, 2008

3. Time of Death

12:56 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

ATLANTIC GENERAL HOSPITAL

4b. City, Town, or Location of Death

BERLIN

4c. County of Death

WORCESTER

5. Social Security Number

216-64-9693

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

52

8. Date of Birth

11/27/1955

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Willards

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

36640 Old Ocean City Rd.

10f. Zip Code

21874

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

shipping/receiving clerk

16b. Kind of Business/Industry

Tyson Poultry

17. Father's Name (First, Middle, Last)

James Emory Griffin

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Elizabeth Lewis

19a. Informant's Name/Relationship (Type, Print)

Paul F. Griffin Sr/brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

36640 Old Ocean City Rd., Willards, MD 21874

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Hall Riverside Cemetery

Date

1/16/08

20c. Location - City or Town, State

Libertytown, MD

21. Signature of Funeral Service Licensee

Holloway Funeral Home Professional Association

22. Name and Address of Facility

501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. ADULT Respiratory Distress Syndrome

Due to (or as a consequence of):

b. COPD

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

064585

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony Perella 9733 Healthway Drive Berlin MD 21811

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

John L. Smith

State Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02717

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH HENRY HILDEBRAND

2. Date of Death

Month Day Year  
JANUARY 26, 2008

3. Time of Death

8:45A M

4a. Facility Name (If not institution, give street and number)

FREDERICK MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

FREDERICK

4c. County of Death

FREDERICK

Funeral  
Director

5. Social Security Number

214-30-1999

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 1, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Union Bridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19 Phillips Lane

10f. Zip Code

21791

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

truck driver

16b. Kind of Business/Industry

petroleum products

17. Father's Name (First, Middle, Last)

Gary Roger Hildebrand

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Biddinger

19a. Informant's Name/Relationship (Type, Print)

Virginia Hildebrand/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19 Phillips Lane Union Bridge, MD 21791

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

All County Cremation 1/28/2008

Date

20c. Location - City or Town, State

Sykesville, MD

21. Signature of Funeral Service Licensee

Catherine O. Hartzler

22. Name and Address of Facility

Hartzler Funeral Home  
404 S. Main St. Woodsboro, MD 21798

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrhythmia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
seconds

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD, PVD, CRI, Diabetes

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D. G. Hildebrand MD

29c. License number

D 66276

29d. Date signed (Month, Day, Year)

January 27<sup>th</sup> 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAN-E-ALI HAIDER, 9210 CORPORATE BLVD, SUITE 100, ROCKVILLE, MD 20850

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760, 44

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02718

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clara Viola Helman

2. Date of Death

January 27 2008

3. Time of Death

2:15 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

204-03-3778

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Mar. 28, 1923

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

302 Sunbrook Lane

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Paul Norman Seilhamer

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude E. Lewis

19a. Informant's Name/Relationship (Type. Print)

Mary L. Wagner/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1033 Fairview Rd., Hagerstown, MD 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rest Haven Cemetery

Date

1/31/2008

20c. Location - City or Town, State

Hagerstown, MD

21. Signature of Funeral Service Licensee

S. Mark Sings

22. Name and Address of Facility

Rest Haven Funeral Chapel

1601 Pennsylvania Ave., Hagerstown, MD 21742

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multi-system organ failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

Diabetes mellitus

Chronic obstructive pulmonary disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Peter W. Clio MD Surgeon

29c. License number

D41129

29d. Date signed (Month, Day, Year)

January 28, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PETER W. CLIO Sinai Hospital 2435 West Belvedere Avenue, Baltimore, Maryland 21215

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

John B. Smith

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02719

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rosalie May Henry

2. Date of Death

January 28 2008

3. Time of Death

7:42 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Citizens Nursing Home

4b. City, Town, or Location of Death

Harford de Grace

4c. County of Death

Harford

5. Social Security Number

494-20-8861

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

96

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

7/13/1911

9. Birthplace (State or Foreign Country)

Iowa

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

818 Matthews Avenue

10f. Zip Code

21001

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dental &amp; Nurses Assistant

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

William Sweeney

18. Mother's Name (First, Middle, Maiden Surname)

Cora Rogers

19a. Informant's Name/Relationship (Type, Print)

Virginia Jacobs (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

818 Matthews Ave. Aberdeen, Maryland 21001

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harford Mem. Gdns.

Date

2/2/08

20c. Location - City or Town, State

Aberdeen, Maryland

21. Signature of Funeral Service Licensee

K. Sweeney

22. Name and Address of Facility

Tarring-Cargo Funeral Home, P.A.  
Aberdeen, Maryland 21001-3399

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. coronary artery disease

Due to (or as a consequence of):

b. chronic pain syndrome

Due to (or as a consequence of):

c. osteoporosis

Due to (or as a consequence of):

d. pneumonia

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Insulin dependent diabetes

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

K. Sweeney

29c. License number

D46412

29d. Date signed (Month, Day, Year)

1/28/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3K S. Union Ave Harford and 21078

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

K. Sweeney

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Henry Rosalie  
Division of Vital Records, P.O. Box 68760, &

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02720

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Harold George Hubachek

2. Date of Death

Month 1/13/2008 Year

3. Time of Death

10:15 a<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Woodside Center

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

539-40-8969

6. Sex  
☒ M ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

7/19/1943

9. Birthplace (State or Foreign  
Country)

Tacoma, WA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

10944 Rocky Mount Way

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates: 196313. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

6

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Systems Analyst

16b. Kind of Business/Industry

Government/Private

17. Father's Name (First, Middle, Last)

Ernest Hubachek

18. Mother's Name (First, Middle, Maiden Surname)

Lucille Schnelle

19a. Informant's Name/Relationship (Type, Print)

Mary Q. Hubachek, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10944 Rocky Mount Way, Silver Spring, MD 20902

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

1/14/2008

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

Ernest J. Colvin

22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Ave.

Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. hepatocellular carcinoma

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. hepatic encephalopathy

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death  
☐ Pregnant at time of death  
☐ Unknown☐ Ectopic pregnancy  
☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Insufficiency

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an  
autopsy  
performed?  
☐ Yes ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
☐ Yes ☐ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☒ Nursing Home☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. Arnold

29c. License number

BA 9675375

29d. Date signed (Month, Day, Year)

1/14/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FARZANA AJMAL MD

9101 2nd Ave., Silver Spring, MD 20910

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

J. Arnold

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02721

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

PHYLLIS MALIE HILL

2. Date of Death

January 18 2008

3. Time of Death

4:22A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

FAHRNEY-KEEDY MEMORIAL HOME

4b. City, Town, or Location of Death

BOONSBORO

4c. County of Death

WASHINGTON

5. Social Security Number

214-36-2242

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

If Under 24 Hrs.

8. Date of Birth

NOV. 30, 1923

9. Birthplace (State or Foreign)

MARYLAND

Usual Residence of Decedent

10a. State  
MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

BOONSBORO

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8507 MAPLEVILLE ROAD

10f. Zip Code

21713

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

ADMINISTRATOR

16b. Kind of Business/Industry

COUNTY BOARD OF ED

17. Father's Name (First, Middle, Last)

GEORGE A. SITES

18. Mother's Name (First, Middle, Maiden Surname)

MAMIE C. FUNKHOUSER

19a. Informant's Name/Relationship (Type, Print)

CHRISTINE A. STOOBS, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5633 MT. CARMEL CHURCH ROAD, KEEDYSVILLE, MD 21756

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

ST. PAULS CEMETERY

Date

1/21/2008

20c. Location - City or Town, State

CLEAR SPRING, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

BAST FUNERAL HOME 7606 OLD NATIONAL PIKE  
BOONSBORO, MARYLAND 2171323a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Dementia  
Due to (or as a consequence of):b. Hypertensive Cardiovascular Disease  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death5x  
15xSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

052323

29d. Date signed (Month, Day, Year)

1/18/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khalid Waseem, M.D., 1126 Opal Court, Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

JAN-22-2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Phyllis, Hill, Hill  
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02722

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Roland W. Haney

2. Date of Death  
Month Day Year

Jan. 13, 2008

3. Time of Death

1639p. M

4a. Facility Name (If not institution, give street and number)

Prince Georges Community Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

250-20-8340

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth (Month, Day, Year)

Jan. 7, 1924

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

MD.

10b. County

Prince Georges

10c. City, Town or Location

Capital Heights

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6305 Field Street

10f. Zip Code

20743

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1943-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Boiler Operator

16b. Kind of Business/Industry

GSA

17. Father's Name (First, Middle, Last)

Tom Haney

18. Mother's Name (First, Middle, Maiden Surname)

Selina Littlejohn

19a. Informant's Name/Relationship (Type, Print)

Henrietta Haney (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6305 Field St., Capital Heights, MD. 20743

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cheltenham Vet. Cem.

Date

1-24-08

20c. Location - City or Town, State

Cheltenham, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lewis Funeral Home  
311 N. Patrick St., Alexandria, VA. 22314

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Fatal Cardiac Arrhythmia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Colon Cancer

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown  
3 ☐ Ectopic pregnancy  
5 ☐ Other (Specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)  
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D58957

29d. Date signed (Month, Day, Year)

Jan. 17, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary Little PGHC, 3001 Hospital Dr., Cheverly, MD. 20785

31. Date filed (Month, Day, Year)

JAN 18 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02723

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Esther Jorolan

2. Date of Death

January 14, 2008

3. Time of Death

10:30 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

7401 New Hampshire Avenue #909

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

261-58-6250

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

84

8. Date of Birth

June 4, 1923

9. Birthplace (State or Foreign Country)

Philippines

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

7401 New Hampshire Ave., # 909

10f. Zip Code

20912

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Research Scientist/Army Hospital

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Valentin Jorolan

18. Mother's Name (First, Middle, Maiden Surname)

Feliciano Plaza

19a. Informant's Name/Relationship (Type, Print)

Mr. Glennon J. Wilhelm, Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11107 Mountain View Lane, Ijamsville, MD 21754

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Date

Jan. 30, 2008

20c. Location - City or Town, State

Smithsburg, MD

21. Signature of Funeral Service Licensee

Richard E. Gray

MO0255

22. Name and Address of Facility

Keeney and Basford PA Funeral Home

106 East Church St., Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASCVD

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DME

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

JAN ~ BRECKER MO OME

29c. License number

D00428

29d. Date signed (Month, Day, Year)

Jan 16 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN ~ BRECKER MO OME

2201 Medical Park Dr Silver Spring MD 20902

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

JAN ~ BRECKER MO OME

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02724

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nellie C. Jackson

2. Date of Death

January 11, 2008

3. Time of Death

6:59 A M

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

Funeral  
Director

5. Social Security Number

217-32-0406

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

8. Date of Birth (Month, Day, Year)

February 10, 1930

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert

10c. City, Town or Location

Prince Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

90 Mason Road

10f. Zip Code

20678

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

Public Schools

17. Father's Name (First, Middle, Last)

Joseph Morris

18. Mother's Name (First, Middle, Maiden Surname)

Lydia Mason

19a. Informant's Name/Relationship (Type, Print)

Ann Jackson - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

90 Mason Road, Prince Frederick, MD 20678

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cheltenham Veterans Cem.

Date

1/24/2008

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

► Gladys A. Sewell

22. Name and Address of Facility

Sewell Funeral Home, 1451 Dares Beach Rd., Prince Frederick, MD 20678

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC HEART DISEASE

Approximate Interval Between Onset and Death

14 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► AT Meunier, M.D.  
Attending Physician

29c. License number

D 19427

29d. Date signed (Month, Day, Year)

1-11-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anwar T. Munshi, M.D.

Prince Frederick, MD 20678

31. Date filed (Month, Day, Year)

JAN 11 2008

32. Registrar's Signature

James B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2008 02725

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Michael Edward Keplinger

2. Date of Death

January 15, 2008

3. Time of Death

9:10p M

Funeral Director

4a. Facility Name (If not institution, give street and number)

39 Pine Bluff Lane

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

5. Social Security Number

221-60-8585

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

35 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth (Month, Day, Year)

October 27, 1972

9. Birthplace (State or Foreign Country)

DE

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

39 Pine Bluff Lane

10f. Zip Code

21921

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Danny E. Atwell

18. Mother's Name (First, Middle, Maiden Surname)

Jeannie Keplinger

19a. Informant's Name/Relationship (Type, Print)

Jeannie Keplinger/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

39 Pine Bluff Lane, Elkton, MD 21921

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Kline Cemetery

Date

January 19, 2008

20c. Location - City or Town, State

Upper Track, WV

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Andrew G. Gee Funeral Home

259 E. Main St., Elkton, MD 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myeloid Sarcoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 months

Sequentially list conditions, if any, leading to immediate cause. Prior Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No

9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown

3 ☐ Ectopic pregnancy

5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☒ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

H. Ferkes, MD

29c. License number

DIS314

29d. Date signed (Month, Day, Year)

January 16, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. Ferkes, MD Seasons Hospice 133 N. Bridge St Elkton MD

31. Date filed (Month, Day, Year)

JAN 18 2008

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02726

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Grace Leedy

2. Date of Death

January 23 2008

3. Time of Death

7:00 PM

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

201-16-0277

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Sept. 18, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

21610 Leiter Street

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Benjamin Frankline Linebaugh

18. Mother's Name (First, Middle, Maiden Surname)

Mary Esta Lum

19a. Informant's Name/Relationship (Type, Print)

Roy E. Gesford (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13314 Herman Myers Rd. Hagerstown, Maryland 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Beaver Creek Cemetery

Date

January 30, 2008

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Jesse L. Davis MO1414

22. Name and Address of Facility

J.L. Davis Funeral Home

12525 Bradbury Ave. Smithsburg, Maryland 21783

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Sepsis

Approximate Interval Between Onset and Death

4-5 days

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Cause of injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

Pneumonia

4-5 days

c. Due to (or as a consequence of):

Acute leukemia

1-2 weeks

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jesse L. Davis

29c. License number

D18019

29d. Date signed (Month, Day, Year)

JAN 27, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VASANT DATTA MD 340 MILL ST HAGERSTOWN MD 21740

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

Jesse L. Davis

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760, Hy.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

H

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02727

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD

LINDSAY

2. Date of Death  
Month Day Year

01

25

2008

3. Time of Death  
M

1645

4a. Facility Name (If not institution, give street and number)

WMHS-BRADDOCK CAMPUS

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

215-20-6352

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

8. Date of Birth (Month, Day, Year)

FEB. 13, 1926

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

ALLEGANY

10c. City, Town or Location

LAVALE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

21 VOCKE DRIVE

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: KOREA

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

RESEARCHER

16b. Kind of Business/Industry

HERCULES, INC.

17. Father's Name (First, Middle, Last)

JOHN C. LINDSAY

18. Mother's Name (First, Middle, Maiden Surname)

MAGGIE GLAZE

19a. Informant's Name/Relationship (Type. Print)

MILDRED LINDSAY / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21 VOCKE DRIVE, LAVALE, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MSVC-ROCKY GAP

Date

01/28/2008

20c. Location - City or Town, State

FLINTSTONE, MD

21. Signature of Funeral Service Licensee

John J. Haffer Jr.

22. Name and Address of Facility

HAFFER FUNERAL SERVICE, P.A.

1302 NATIONAL HIGHWAY, LAVALE, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Fibrosis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

unkn

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus; Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Thomas E. Chappell MD

29c. License number

D 35735

29d. Date signed (Month, Day, Year)

1/26/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas E. Chappell MD 9125 Ston D Cumberland MD

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

John J. Haffer Jr.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760, 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02728

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Michaela M. Litts</b>  |  |   |  | 2. Date of Death<br>Month <b>January</b> Day <b>15</b> Year <b>2008</b>   |  |   |  | 3. Time of Death<br><b>11:52A.M</b>  |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>3052 Piano Lane</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |  |   |  | 4c. County of Death<br><b>Montgomery</b>   |  |  |  |
| 5. Social Security Number<br><b>152-44-6292</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>54</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 18, 1953</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>New Jersey</b>  |  |  |  |
| Usual Residence of Decedent   |  |   |  |   |  |   |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Silver Spring</b>   |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
| 10e. Street and Number<br><b>3052 Piano Lane</b>  |  |   |  | 10f. Zip Code<br><b>20904</b>   |  |   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates <b>1976-1976</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary <b>12</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Security Officer</b>  |  |   |  | 16b. Kind of Business/Industry<br><b>private</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Michael F. Shard</b>  |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Agnes Eileen McMananan</b>  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Earl W. Litts -husband</b>   |  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3052 Piano Lane Silver Spring, Maryland 20904</b> |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  |   |  | Date<br><b>1/20/2008</b>   |  | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b> |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  |   |  | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, PA<br/>4400 Powder Mill Road Beltsville, Maryland 20705</b>                  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Stroke</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |   |  |   |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  |   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |   |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  |   |  |   |  | 29c. License number<br><b>D37186</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>January 16, 2008</b>   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Bruce Rind, M.D. 5225 Wisconsin Avenue, N.W., #401 Washington, D.C. 20015</b>  |  |   |  |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 17 2008</b>   |  |   |  | 32. Registrar's Signature<br>   |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

5

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Register AMEND#18 per FH1/22/08, BW, MCo

## Certificate of Death

Reg. No. 2008 02729

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Steven Lewis

2. Date of Death  
Month Day Year  
1 14 083. Time of Death  
12:05 PM

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

216-64-2975

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

8. Date of Birth (Month, Day, Year)

5/17/1952

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10120 Kinross Avenue

10f. Zip Code

20901

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Compensation Specialist

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Theodore G. Lewis

18. Mother's Name (First, Middle, Maiden Surname)

Frances Bowe

19a. Informant's Name/Relationship (Type, Print)

Candace Lewis / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10120 Kinross Ave., Silver Spring, MD 20901

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crem.

Date

1/17/08

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Thomas H. Clyburn

22. Name and Address of Facility McGuire Funeral Service, Inc

7400 Georgia Ave., N.W. Washington, DC 20002

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. AML relapse  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hepatic Failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Bai

29c. License number

A04176435618143

29d. Date signed (Month, Day, Year)

Jan 14, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Q. William Gai 22 S. Greene Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

Karen H. Sparte

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2008 02730

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Louis Olin Larson

2. Date of Death  
Month Day Year  
January 15, 20083. Time of Death  
6:45 p<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

390-18-2008

6. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
89 Yrs.8. Date of Birth (Month, Day, Year)  
Oct. 1, 19189. Birthplace (State or Foreign Country)  
Wisconsin

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10713 Jamaica Drive

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1942-4513. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Furniture Salesman

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Louis Austin Larson

18. Mother's Name (First, Middle, Maiden Surname)

Louise Dorothy Johnson

19a. Informant's Name/Relationship (Type, Print)

Barbara Larson-Dixon/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21067 Calhoun Corners Terrace, #100, Ashburn, VA 20147

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

Jan. 18,  
2008

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.

500 University Blvd, W. Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and Death

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Immediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Carolyn Sporn

29c. License number

D58461

29d. Date signed (Month, Day, Year)

Jan 15, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAROLYN SPORN 1500 FOREST GLEN RD., SILVER SPRING, MD 20910

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

Bryan H. Sporn

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02731

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Harley Russell Long Sr.

2. Date of Death

Month Day Year  
1 17 08

3. Time of Death

1525 M

4a. Facility Name (If not institution, give street and number)

Good Samaritan

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

526-90-7815

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

February 26, 1950

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Conowingo

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4 Miller's Park Drive

10f. Zip Code

21918

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Plant Operations

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Harley Francis Long

18. Mother's Name (First, Middle, Maiden Surname)

Irene Ludlum

19a. Informant's Name/Relationship (Type, Print)

Donna D. Long/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Millers Park Drive Conowingo, Maryland 21918

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

R.T. Foard Funeral Home P.A.

Date

1-21-08

20c. Location - City or Town, State

Rising Sun, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

R. T. Foard Funeral Home, P.A.

111 S. Queen Street Rising Sun, Maryland 21911

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Probable Myocardial Infarction

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Terrence L. Baker

29c. License number

110058570

29d. Date signed (Month, Day, Year)

January 18 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Terrence L. Baker Good Samaritan Hospital Baltimore 21239

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 22 2008

32. Registrar's Signature

Terrence L. Baker

Long Harley  
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02732

1- For  
State  
Registrar

|  |   |                               |  |   |   |  |  |  |   |                                   |  |  |
|--|---|-------------------------------|--|---|---|--|--|--|---|-----------------------------------|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>FLOZELL LEETH</b>  |                               |  |   | 2. Date of Death<br>Month Day Year<br><b>JANUARY 15, 2008</b> |  |  |  | 3. Time of Death<br><b>9:40 P M</b>                                     |                                   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>VA MARYLAND HEALTH CARE SYSTEM</b> |                               |  |   | 4b. City, Town, or Location of Death<br><b>PERRY POINT</b>    |  |  |  | 4c. County of Death<br><b>CECIL</b>                                     |                                   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>420-16-7593</b>   |                               | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.              |  | 8. Date of Birth (Month, Day, Year)<br><b>NOV 20, 1920</b> |  | 9. Birthplace (State or Foreign Country)<br><b>ALABAMA</b>              |                                   |  |  |
|  | Usual Residence of Decedent   |                               |  |   |   |  |  |  |   |                                   |  |  |
| 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>HARFORD</b> |  | 10c. City, Town or Location<br><b>ABERDEEN</b>  |   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |                                   |  |  |
| 10e. Street and Number<br><b>1418 WILLSHIRE DRIVE</b>  |   |                               |  | 10f. Zip Code<br><b>21001</b>   |   |  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |                                   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1942-62</b> |   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |                                   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   |                               |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MECHANIC</b>  |   |  |  | 16b. Kind of Business/Industry<br><b>US ARMY</b>   |   |                                   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>HUBERT LEETH</b>   |   |                               |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HANEY TWITTY</b>   |  |  |   |                                   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ALMA C. LEETH / SPOUSE</b>  |   |                               |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1418 WILLSHIRE DRIVE, ABERDEEN, MARYLAND 21001</b>                                       |  |  |   |                                   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                               |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST VET.</b>   |   | Date<br><b>01/28/08</b>  |  | 20c. Location - City or Town, State<br><b>OWINGS MILLS, MD</b>                                 |   |                                   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |                               |  | 22. Name and Address of Facility<br><b>LISA SCOTT FUNERAL HOME, P.A.<br/>552 LEWIS STREET, HAVRE DE GRACE, MD 21078</b>   |   |  |  |  |   |                                   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>CVA</b><br>Approximate Interval Between Onset and Death<br><b>Unknown</b>   |   |                               |  |   |   |  |  |  |   |                                   |  |  |
| 23b. If female, was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |   |                               |  |   |   |  |  |  |   |                                   |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |   |                               |  |   |   |  |  |  |   |                                   |  |  |
| 23d. Date of delivery<br>Month Day Year  |   |                               |  |   |   |  |  |  |   |                                   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                               |  |   |   |  |  |  |   |                                   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |                               |  |   |   |  |  |  |   |                                   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                               |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |  |   |                                   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                               |  | 26. Place of Death Check only one<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |                                   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |                               |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   | 28d. Describe how injury occurred |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   |                               |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |   |                                   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |                               |  |   |   |  |  |  |   |                                   |  |  |
| 29b. Signature and title of certifier<br>  |   |                               |  | 29c. License number<br><b>D42800</b>  |   |  |  | 29d. Date signed (Month, Day, Year)<br><b>JANUARY, 15 2008</b>                                 |   |                                   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THOMAS BIONDO, M.D. VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902</b>   |   |                               |  |   |   |  |  |  |   |                                   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 18 2008</b>  |   |                               |  | 32. Registrar's Signature<br>   |   |  |  |  |   |                                   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02733

1- For  
State  
Registrar

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>RAY A LEAK</b>   |  | 2. Date of Death<br>Month Day Year<br><b>JANUARY 15 2008</b>  |  | 3. Time of Death<br><b>7:10 A<sup>M</sup></b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>JOHNS HOPKINS BAYVIEW MEDICAL CENTER</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>213-72-6163</b>   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>April 16, 1956</b> | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>  |
|   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>707 E. 41 Street</b>   |  | 10f. Zip Code<br><b>21218</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Mechanic</b>  |  | 16b. Kind of Business/Industry<br><b>Self Employed</b>   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Mayso Leak, Sr.</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Luenet Caple</b>  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jo Anne Leak Wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>707 E., 41 St., Baltimore, Md. 21218</b>  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Church of The Lord Jesus Christ</b>  |  | 20c. Location - City or Town, State<br><b>Ironsides, Maryland</b>  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>M00668   |  | 22. Name and Address of Facility<br><b>Williams Funeral Home, P.A.<br/>4270 Hawthorne Rd., Indian Head, Md. 20640</b>   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>NECROTIC SMALL BOWEL</b><br>Due to (or as a consequence of):<br>b. <b>ISCHEMIC CARDIOMYOPATHY</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><b>5 days</b><br><b>5 years</b>   |  |  |
| To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>gastric ulcer perforation, coronary artery disease, hypertension</b>   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)<br><b>M</b>   |  | 28b. Time of Injury<br><b>M</b>  |
|   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>   |  |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>REG-000</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JANUARY 15, 2008</b>  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MEGHAN A. ARNOLD MD 4940 EASTERN AVENUE BALTIMORE MD 21244</b>   |  |   |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>JAN 18 2008</b>   |  | 32. Registrar's Signature<br>   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02734

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Lawrence Carl Miller, Sr.

2. Date of Death

Month Day Year  
1/15/2008

3. Time of Death

6:45 a M

4a. Facility Name (If not institution, give street and number)

4214 Van Buren St.

4b. City, Town, or Location of Death

University Park

4c. County of Death

Prince George's

5. Social Security Number

577-09-8756

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

8. Date of Birth (Month, Day, Year)

10/28/1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

University Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4214 Van Buren Street

10f. Zip Code

20782

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Attorney

16b. Kind of Business/Industry

U.S. House of Representatives

17. Father's Name (First, Middle, Last)

Lewis Miller

18. Mother's Name (First, Middle, Maiden Surname)

Henriette Reichmann

19a. Informant's Name/Relationship (Type, Print)

Lawrence C. Miller, JR, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

119 Timberbrook Lane #302, Gaithersburg, MD 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

1/17/2008

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

Ernest G. Colvin II

22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Ave.

Hyattsville, MD 20781

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Myelodysplastic Syndrome

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cardiomyopathy

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael Berard, MD

29c. License number

D26207

29d. Date signed (Month, Day, Year)

January 16, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Berard, MD 7305 Baltimore Blvd., College Park, MD 20740

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

Kane H. Spauld

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02735

1- For State Registrar

|   |  |   |   |  |   |  |   |  |
|---|--|---|---|--|---|--|---|--|
| Physician / Medical Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Hubert Calvin Mentz</b>   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>January 6, 2008</b>  |  | 3. Time of Death<br><b>10:10 AM</b>                                     |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Union Hospital of Cecil County</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Elkton</b>   |  | 4c. County of Death<br><b>Cecil</b>                                     |  |
| Funeral Director  | 5. Social Security Number<br><b>234-24-6552</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.                             | 8. Date of Birth (Month, Day, Year)<br><b>March 28, 1922</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>             |  |
|   | Usual Residence of Decedent  |   |   |  | 10. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Cecil</b>   |  | 10c. City, Town or Location<br><b>Elkton</b>  |  | 10d. Inside City Limits   |  |
|   | 10e. Street and Number<br><b>302 Skipjack Court</b>  |   |   |  | 10f. Zip Code<br><b>21921</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>                   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1942-45</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>5</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Auto Mechanic</b>   |  | 16b. Kind of Business/Industry<br><b>U.S. Government</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Grover Cleveland Mentz</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sallie Kelley</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Geneva D. Mentz / Wife</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>302 Skipjack Court, Elkton, Maryland 21921</b>  |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Elkton Cemetery</b>  |  | 20c. Date<br><b>January 11, 2008</b>  |  | 20d. Location - City or Town, State<br><b>Elkton, Maryland</b>          |  |
|   | 21. Signature of Funeral Service Licensee  |   | 22. Name and Address of Facility<br><b>Crouch Funeral Home</b><br><b>127 South Main Street, North East, Maryland 21901</b>  |  |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. <b>Aspiration</b><br/>Due to (or as a consequence of):</p> <p>b. <b>myocardial infarction</b><br/>Due to (or as a consequence of):</p> <p>c. <b>Coronary artery disease</b><br/>Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 15%;"> <p>Approximate Interval Between Onset and Death<br/><b>minutes</b><br/><b>hours</b><br/><b>years</b></p> </div> </div> |   |   |  |   |  |   |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |   |  | 23d. Date of delivery<br>Month Day Year                                 |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes</b><br><b>Hypertension</b>  |  |   |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |   |  |
| 29a. Certify (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |   |  |   |  |
| 29b. Signature and title of certifier   |  | 29c. License number<br><b>D45155</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>01/09/2008</b>                     |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. JOHN MULVEY III WEST HIGH STREET SUITE 309 ELKTON MD. 21921</b>  |  |   |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 11 2008</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |   |  |   |  |

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1- For State Registrar **Amend Item 20b** per fn, 8876, 02/16/08 ddb  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death  
Reg. No. 2008 02736

|  |  |  |   |   |  |  |  |  |   |   |  |
|--|--|--|---|---|--|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Ethel Virginia Myers</b>  |  |   | 2. Date of Death<br>Month Day Year<br><b>January 19, 2008</b>   |  |  | 3. Time of Death<br><b>10:40 P<sup>M</sup></b>   |  |   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Homewood at Williamsport</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Williamsport</b>   |  |  | 4c. County of Death<br><b>Washington</b>   |  |   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-20-1582</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>97</b> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><b>April 26, 1910</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |   |  |
|  | Usual Residence of Decedent  |  |   | 10a. State<br><b>Maryland</b>   |  |  | 10b. County<br><b>Washington</b>   |  |   | 10c. City, Town or Location<br><b>Williamsport</b>                      |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   | 10e. Street and Number<br><b>16505 Virginia Avenue</b>  |  |  | 10f. Zip Code<br><b>21795</b>  |  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b>   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Charles Franklin Myers</b>   |  |   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie May Bowman</b>  |  |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Karen D. Kiley Friend</b>   |  |   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14 West Potomac Street, Williamsport, Md. 21795</b>  |  |   |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rest Haven Cemetery</b>  |  |  | Date<br><b>01/24/2008</b>  |  |   | 20c. Location - City or Town, State<br><b>Hagerstown, Maryland</b>      |  |
|  | 21. Signature of Funeral Service Licensee<br><b>R. Lee Brady</b>   |  |   | 22. Name and Address of Facility<br><b>Andrew K. Coffman Funeral Home, Inc.<br/>40 East Antietam St., Hagerstown, Md. 21740</b>   |  |  |  |  |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Coronary Artery Disease</b>   |  |   |   |  |  |  |  |   |   |  |
|  | 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |   |  |  |  |  |   |   |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |  |  |   | 23d. Date of delivery<br>Month Day Year                                 |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Arteriofibrocalculation, Ischemic<br/>Cardiomyopathy, Chronic<br/>Hypertension.</b>   |  |  |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                           |   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |   |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |   |  |  |  |  |   |   |  |
| 29b. Signature and title of certifier<br><b>H. E. Medical Director</b>   |  |  | 29c. License number<br><b>D17067</b>  |   |  |  | 29d. Date signed (Month, Day, Year)<br><b>1/21/2008</b>  |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Gerard E. Metzger, MD 1324 1/2 Ave, Ste 101 Hagerstown, Md 21742</b>  |  |  |   |   |  |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 22 2008</b>  |  |  | 32. Registrar's Signature<br><b>James S. Spiller</b>  |   |  |  |  |  |   |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02737

Physician/  
Medical Examiner1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Paula Jo McClain

2. Date of Death  
Month Day Year  
January 22, 20083. Time of Death  
0745 hrsFuneral  
Director4a. Facility Name (if not institution, give street and number)  
Calvert Memorial Hospital4b. City, Town, or Location of Death  
Prince Frederick4c. County of Death  
Calvert5. Social Security Number  
220-88-48316. Sex  
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)  
45 Yrs.If Under 1 Year  
Months Days Hours Min.8. Date of Birth (MM/DD/YYYY)  
12/27/19629. Birthplace (State or  
Foreign Country) PA

Usual Residence of Decedent

10a. State  
MD10b. County  
Calvert

10c. City, Town or Location

Chesapeake Beach

10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number

3512 Elizabeth Court

10f. Zip Code

20732

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No specify:14. Race - American Indian, Black,  
White, etc.  
Specify: white15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) College (1-4 or 5+)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done  
during most of working life. DO NOT use retired)

School bus aide

16b. Kind of Business/Industry

Board of Education

17. Father's Name (First, Middle, Last)

Robert John McClain

18. Mother's Name (First, Middle, Maiden Surname)

Marjorie Kay Weyer

19a. Informant's Name/Relationship (Type, Print)

Robert J. McClain, father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3512 Elizabeth Court, Chesapeake Beach, MD 20732

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other Specify:20b. Place of Disposition (Name of cemetery,  
cemetery or other place)

Metropolitan Crematory 01-27-08

Date

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

*William R. Grom*

22. Name and Address of Facility

Rausch Funeral Home, P.A.

8325 Mt. Harmony Lane, Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease  
or condition resulting in death)a. Atherosclerotic cardiovascular disease  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying Cause  
(Disease or injury that initiated  
events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED☐ AMENDED

#23a, PTL 27, per ME, e876, 2/4/08 TT

IF FEMALE:

23b. Was decedent pregnant in the  
past 12 months?1 ☐ Yes 2 ☐ No 3 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus; obesity; Chronic obstructive pulmonary  
disease (COPD)

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc.  
(Specify)28f. Location (Street and Number or Rural Route Number, City  
or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

*Ling Li*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 23, 2008

30. Name and address of person who completed cause of death (Item 23a)

Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

JAN 28 2008

32. Registrar's Signature

*Paula McClain*

1149A

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any  
injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008

02738

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Stanton E. Morsell

2. Date of Death

Month

Day

Year

JAN

13

2008

3. Time of Death

11:49 PM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

214-28-3942

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 1, 1926

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3727 Columbus Drive

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Howard E. Morsell

18. Mother's Name (First, Middle, Maiden Surname)

Mary Alice Sewell

19a. Informant's Name/Relationship (Type, Print)

Emma Easton/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6010 Solomons Island Rd. Huntingtown, MD 20638

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Plum Pt. UMC Cem.

Date

1/19/2008

20c. Location - City or Town, State

Huntingtown, MD

21. Signature of Funeral Service Licensee

Gladys G. Sewell

22. Name and Address of Facility

Sewell Funeral Home  
1451 Dares Beach Road  
Prince Frederick, MD 2067823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ATRIAL FIBRILLATION  
SEIZURE DISORDER

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Tasneem Lakhani

29c. License number

D285945

29d. Date signed (Month, Day, Year)

1/14/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TASNEEM LAKHANI, 2835 SMITH AVE, SUITE 203, BALTO MD 21208

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

Karen B. Spiller

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02739

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WINIFRED MCKAY

2. Date of Death  
Month Day Year  
JANUARY 11 20083. Time of Death  
8:55 A M

4a. Facility Name (If not institution, give street and number)

FREDERICK MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

FREDERICK

4c. County of Death

FREDERICK

Funeral  
Director

5. Social Security Number

213-48-0795

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

8. Date of Birth (Month, Day, Year)

Oct 28, 1915

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Frederick

10c. City, Town or Location

Emmitsburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

335 S. Seton Avenue

10f. Zip Code

21727

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)  
5+16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Religious Community  
Daughters of Charity

17. Father's Name (First, Middle, Last)

James McKay

18. Mother's Name (First, Middle, Maiden Surname)

Mary Morgan

19a. Informant's Name/Relationship (Type, Print)

Sister Camilla Harant Superior

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

333 South Seton Ave, Emmitsburg, MD 21727

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory, or other place)St. Joseph's  
Provincial House

Date

1/15/2008

20c. Location - City or Town, State

Emmitsburg, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Myers-Durboraw Funeral Home  
210 W. Main Street, Emmitsburg, MD 2172723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Due to (or as a consequence of):  
Subdural Hematoma

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☒ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)

JAN 8, 2008

28b. Time of  
injury

2300

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Fall while walking

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

AT HOME

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)333 S. Seton Avenue  
Emmitsburg, Maryland29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0052950

29d. Date signed (Month, Day, Year)

January 11, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lambert C. Smith MD, 400 W. Seventh St, Frederick, MD 21701

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

WJZ  
1State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02740

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Edna Mavis McAvoy

2. Date of Death

Jan. 14, 2008

3. Time of Death

1940 M

4a. Facility Name (If not institution, give street and number)

Salisbury Rehab Nursing Ctr.

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

579-20-7801

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11/22/1922

9. Birthplace (State or Foreign Country)

Missouri

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

200 Civic Ave.

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

agent

16b. Kind of Business/Industry

real estate

17. Father's Name (First, Middle, Last)

Turrel William Waggoner

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Means

19a. Informant's Name/Relationship (Type. Print)

Patricia A. Waggoner/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1205 Ocean Parkway, Berlin, MD 21811

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salisbury Crematory

Date

1/16/08

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

David H. Thompson CFSP

22. Name and Address of Facility

Holloway Funeral Home Professional Association

501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. terminal cancer

Due to (or as a consequence of):

b. chronic obstructive pulmonary disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician:2 ☐ Medical Examiner:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William H. Robins, M.D.

29c. License number

029349

29d. Date signed (Month, Day, Year)

1/15/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William H. Robins, M.D., 200 Civic Ave., Salisbury, MD 21804

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

David H. Thompson

State  
RegistrarMavis McAvoy  
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02741

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Norman Dale Macon

2. Date of Death

Month 1 Day 16 Year 08

3. Time of Death

5:25 AM

4a. Facility Name (If not institution, give street and number)

Coastal Hospice At the Lake

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

523-42-8492

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

6/2/1937

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

505 Washington St.

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: Navy13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4or 5+)  
416a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

electrical contractor

16b. Kind of Business/Industry

electrical

17. Father's Name (First, Middle, Last)

Claude Macon

18. Mother's Name (First, Middle, Maiden Surname)

Bertie Powell

19a. Informant's Name/Relationship (Type, Print)

Valerie Dawson/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

709 S. Kaywood Dr., Salisbury, MD 21804

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Salisbury Crematory

Date

1/17/08

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

Ketterer Funeral Home Professional Association

22. Name and Address of Facility

501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. CARCINOMA OF LUNGS

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 MD  
1 VA

29c. License number

00058410

29d. Date signed (Month, Day, Year)

1/16/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHURCHMAN WARREN COASTAL HOSPICE P.O. BOX 1733 SALISBURY MD 21802

31. Date filed (Month, Day, Year)

JAN 18 2008

32. Registrar's Signature

Norman D. Macon

State  
Registrar

Norman D. Macon

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02742

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

MARY LAURITA PRANGER

2. Date of Death

1/11/2008

3. Time of Death

5:38 P<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

31905 GRIFFITH DR

4b. City, Town, or Location of Death

GALENA

4c. County of Death

KENT

5. Social Security Number

530-16-6560

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

8. Date of Birth (Month, Day, Year)

02/13/1927

9. Birthplace (State or Foreign Country)

KS

Usual Residence of Decedent

10a. State

MD

10b. County

KENT

10c. City, Town or Location

GALENA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

31905 GRIFFITH DR.

10f. Zip Code

21635

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (1-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Lawrence Ross

18. Mother's Name (First, Middle, Maiden Surname)

Mary Bissing

19a. Informant's Name/Relationship (Type, Print)

Karen A. Duda -daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9104 Hendry Terrace Urbana, Maryland 21704

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Md. Veterans Cemetery

Date

1/23/2008

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, PA  
4400 Powder Mill Road Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aortic Stenosis

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 year

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension  
Diabetes

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D58824

29d. Date signed (Month, Day, Year)

1/14/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Anthony Donaher, M.D. 119 North Main Street Galena, Maryland 21635

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at (410) 528-1234.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02743

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

CHARLES POSEY

2. Date of Death

Month 01 Day 09 Year 2008

3. Time of Death

2:00 PM

4a. Facility Name (If not institution, give street and number)

6216 Kennedy St.

4b. City, Town, or Location of Death

Riverdale

4c. County of Death

Prince Georges

5. Social Security Number

578-40-9393

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth (Month, Day, Year)

Oct 3, 1932

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Riverdale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6216 Kennedy St.

10f. Zip Code

20737

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1965-69

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Govt.

17. Father's Name (First, Middle, Last)

James Posey

18. Mother's Name (First, Middle, Maiden Surname)

William Jefferson

19a. Informant's Name/Relationship (Type, Print)

Dorothy Posey (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6216 Kennedy St., Riverdale, Md 20737

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Art. Nat. Cem.

Date

i-24-08

20c. Location - City or Town, State

Arlington, Va.

21. Signature of Funeral Service Licensee

Francis B. Hunt

22. Name and Address of Facility

Hunt Funeral Home  
908 Kennedy St. NW, Wash. DC. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PANCREATIC CANCER

Approximate Interval Between Onset and Death

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael J. Latenta MD

29c. License number

D 21438

29d. Date signed (Month, Day, Year)

January 10, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL J. LATENTA MD D 21438 445 DEFENSE HWY ANNAPOLIS MD 21401

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

James B. Hunt

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Registrar: This certificate must be filed with the Registrar within 24 hours after death.

To the Registrar: This certificate must be filed with the Registrar within 24 hours after death.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Florence Parsons

2. Date of Death

Month 1 Day 17 Year 2008

3. Time of Death

5:55 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

5 Washington St.

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

5. Social Security Number

214-34-5848

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
8/31/1912

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Berlin

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5 Washington St.

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Algie Ellis Wimbrow

18. Mother's Name (First, Middle, Maiden Surname)

Della Oliphant

19a. Informant's Name/Relationship (Type, Print)

Beverly Carter / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

31 Cedarhill Rd., Randallstown, MD 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evergreen Cemetery

Date

1/21/2008

20c. Location - City or Town, State

Berlin, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

The Burbage Funeral Home

108 William St., Berlin, MD 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line

Immediate Cause (Final disease or condition resulting in death)

a. C. diff. Colitis

Due to (or as a consequence of)

b. doxycycline

Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of)

d. Due to (or as a consequence of)

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12417 Ocean Gateway, As Ocean City MD 21842

31. Date filed (Month, Day, Year)

JAN 18 2008

32. Registrar's Signature

Beverly H. Spence

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02745

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Loretta Fay Robinson

2. Date of Death

Month  
01Day  
11Year  
2008

3. Time of Death

8:30 P.M.

4a. Facility Name (If not institution, give street and number)

NMS Healthcare of Hagerstown

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

169-26-2052

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

11/23/1933

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14014 Marsh Pike

10f. Zip Code

21742

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Store Clerk

16b. Kind of Business/Industry

Retail Sales

17. Father's Name (First, Middle, Last)

Arthur L. Smith

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice Schultz

19a. Informant's Name/Relationship (Type, Print)

Kevin E. Robinson Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2392 Cito Road, Big Cove Tannery, PA 17212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Marburg Memorial Gardens

Date

01/16/2008

20c. Location - City or Town, State

Hanover, PA

21. Signature of Funeral Service Licensee

S.V. CC 0354

22. Name and Address of Facility

Kenworthy Funeral Home, Inc., 269 Frederick Street  
Hanover, PA 17331

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cerebrovascular Accident

Due to (or as a consequence of):

b. Respiratory Failure

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10x

10x

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

WJL 2

29c. License number

052323

29d. Date signed (Month, Day, Year)

01-14-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Muhammad Waseem, MD., 1126 Opal Court, Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

Kenna B. Spauld

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 403-361-0036.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02746

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner1. Decedent's Name (First, Middle, Last)  
Edwin F. Rice2. Date of Death  
Month Day Year  
January 13 20083. Time of Death  
0811 MFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Peninsula Regional Medical Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number  
098-14-30926. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
Yrs. 858. Date of Birth  
(Month, Day, Year)  
5/14/19229. Birthplace (State or Foreign  
Country)  
New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6553 Brick Kiln Road

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: Army13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

exterminator/truck Driver

16b. Kind of Business/Industry

exterminator/trucking

17. Father's Name (First, Middle, Last)

Walter Charles Rice

18. Mother's Name (First, Middle, Maiden Surname)

Louise Christine Williamson

19a. Informant's Name/Relationship (Type, Print)

Linda Ehrisman/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8569 Wintergreen Place, Delmar, MD 21875

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)  
Wicomico Memorial  
Park

Date

1/16/08

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

David H. Thompson

22. Name and Address of Facility

Holloway Funeral Home Professional Association  
501 Snow Hill Rd., Salisbury, MD 2180423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Septic Shock

Due to (or as a consequence of):

b. Toxic megacolon

Due to (or as a consequence of):

c. Clostridium Difficile Diarrhea

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Paul R. Fleury

29c. License number

P24872

29d. Date signed (Month, Day, Year)

1/14/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL FLEURY 305 TENTH ST

Pocomoke City MD 21851

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

John K. Apple

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02747

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |                                |  |  |
|--|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Charlotte Joan Snyder</b>   |  | 2. Date of Death<br>Month <b>January</b> Day <b>27</b> Year <b>2008</b>   |                                | 3. Time of Death<br><b>7:10 P M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Julia Manor Health Care Center</b>  |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>   |                                | 4c. County of Death<br><b>Washington</b>   |  |
| 5. Social Security Number<br><b>214-48-4376</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 19, 1930</b> |
| 9. Birthplace (State or Foreign Country)<br><b>California</b>  |  | Usual Residence of Decedent   |                                |  |  |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Washington</b>   | 10c. City, Town or Location<br><b>Hagerstown</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>640 Northern Ave.</b>   |  | 10f. Zip Code<br><b>21742</b>   |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b>College</b>  |                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |
| 16b. Kind of Business/Industry<br><b>Home</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>William L. Thomas</b>   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary L. Bowen</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>David T. Snyder (Son)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13811 Northcrest Rd. Hagerstown, Maryland 21742</b>   |                                |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>   |                                | 20c. Location - City or Town, State<br><b>Smithsburg, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>J. L. Davis MO1414</b>   |  | 22. Name and Address of Facility<br><b>J.L. Davis Funeral Home<br/>12525 Bradbury Ave. Smithsburg, Maryland 21763</b>   |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Myelodysplastic Syndrome</b><br>Due to (or as a consequence of):<br><b>Leukemia</b><br>Due to (or as a consequence of):<br><b>Spinal Stenosis</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><b>5y</b><br><b>5y</b><br><b>7y</b>   |                                |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death<br><input type="checkbox"/> Unknown   |                                | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  |  |   |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br><b>M</b>  |  |
|  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |                                | 29c. License number<br><b>P52323</b>   |  |
|  |  | 29d. Date signed (Month, Day, Year)<br><b>01-28-2008</b>  |                                |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Muhammad Waseem OPAL medical group Hagerstown, MD.</b>  |  |   |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 01 2008</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |                                |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, U.S.

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02748

1- For  
State  
Registrar

|   |   |  |   |  |  |  |   |  |  |  |
|---|---|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Sara Jane Stup  |  |   |  |  |  | 2. Date of Death<br>Month Day Year<br>January 27, 2008  |  | 3. Time of Death<br>5:55 PM M                        |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Homewood at Crumland Farms  |  |   |  | 4b. City, Town, or Location of Death<br>Frederick  |  | 4c. County of Death<br>Frederick  |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>214-54-0118  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>90 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Aug. 14, 1917  |  | 9. Birthplace (State or Foreign Country)<br>Maryland |  |
|   | Usual Residence of Decedent   |  |   |  |  |  | 10a. State<br>Maryland  |  | 10b. County<br>Frederick                             |  |
| To Be Completed by Funeral Director           | 10c. City, Town or Location<br>Frederick  |  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 10e. Street and Number<br>104 Mercer Court, Suite 12-1B   |  |  |  |
|   | 10f. Zip Code<br>21701  |  | 10g. Citizen of What Country?<br>U.S.A.   |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  |  |  | 16b. Kind of Business/Industry<br>Onw Home  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>Harry Milton Free  |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Estie Kline  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Carol Ann Kepler, daughter  |  |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2001 Tadcaster Road, Catonsville, MD 21228   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rocky Springs Cemetery Feb. 1, 2008 Frederick, MD   |  |  |  | 20c. Location - City or Town, State   |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>[Signature]  |  | 22. Name and Address of Facility<br>Keeney and Basford PA Funeral Home<br>MO0255 106 East Church St., Frederick, MD 21701   |  |  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Dementia<br>Approximate Interval Between Onset and Death<br>Years                                   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Thyroid Cancer<br>Osteoporosis  |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                  |  |  |  | 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  | 29b. Signature and title of certifier<br>[Signature]  |  | 29c. License number<br>D 16428                       |  |
|   | 29d. Date signed (Month, Day, Year)<br>1/28/08  |  |   |  |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Casper E. Cline III, M.D., 300 West Ninth Street, Frederick, MD 21701   |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>FEB 01 2008  |  |   |  |  |  | 32. Registrar's Signature<br>[Signature]  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02749

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |  |
|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Ray Junior Shank  |  | 2. Date of Death<br>Month: January Day: 25 Year: 2008  |  | 3. Time of Death<br>3:42 P M   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Frederick Memorial Hospital   |  | 4b. City, Town, or Location of Death<br>Frederick  |  | 4c. County of Death<br>Frederick   |  |
| Funeral<br>Director   | 5. Social Security Number<br>215-36-6126  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (in yrs. last birthday)<br>67 Yrs.  | 8. Date of Birth (Month, Day, Year)<br>Aug. 21, 1940   | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|   | Usual Residence of Decedent   |  | 10a. State<br>Maryland   |  | 10b. County<br>Frederick   |  |
| To Be Completed by Funeral Director   | 10c. City, Town or Location<br>Middletown   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>8022A Old Hagerstown Road  |  |
|   | 10f. Zip Code<br>21769  |  | 10g. Citizen of What Country?<br>USA   |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
|   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): 8 College (1-4or 5+):   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Laborer   |  | 16b. Kind of Business/Industry<br>Construction   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Melvin Peter Shank   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Nellie Virginia Haupt   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Sharon Bieluch / niece  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11706 General Hill Circle, Sharpsburg, MD 21782   |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Smithsburg Crematory   |  | 20c. Location - City or Town, State<br>Jan. 31, 2008 Smithsburg, Maryland  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>504 Main Street<br>Ricketts Funeral Home Myersville, MD 21773  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Anoxic encephalopathy<br>Due to (or as a consequence of):<br>b. metabolic acidosis<br>Due to (or as a consequence of):<br>c. Acute renal failure<br>Due to (or as a consequence of):<br>d. |  | Approximate Interval Between Onset and Death   |  |  |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br>9 Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M   |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |
| 29b. Signature and title of certifier<br>   |   | 29c. License number<br>2003516   |  | 29d. Date signed (Month, Day, Year)<br>Jan 26, 2008  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Myung Hee Nam, M.D., Frederick Memorial Hospital, 400 W 7th St., Frederick, MD 21701  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 01 2008  |   | 32. Registrar's Signature<br>  |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Division or Vital Records, P.O. Box 68760, 4

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02750

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

James R. Shillinger

2. Date of Death

January 16 2008

3. Time of Death

3:27 A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

177-38-2508

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60

8. Date of Birth

Feb. 23, 1947

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Darnestown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12604 Triple Crown Road

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Criminal Investigator

16b. Kind of Business/Industry

Department of labor

17. Father's Name (First, Middle, Last)

Alvin James Shillinger

18. Mother's Name (First, Middle, Maiden Surname)

Frances Jane Cenna

19a. Informant's Name/Relationship (Type, Print)

Sheila A. Shillinger /Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12604 Triple Crown Road, Darnestown, MD 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan  
Crematory

Date

January 19  
2008

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

TRACY A. STINE

22. Name and Address of Facility

DeVol Funeral Home, 10 East Deer Park Drive,  
Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Breast Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Genevieve Wroblewski, M.D.

29c. License number

D0064615

29d. Date signed (Month, Day, Year)

January 16, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Genevieve Wroblewski, M.D., 1355 Piccard Drive, Suite 100, Rockville, MD 20850

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

KAREN H. SPATE

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital (or Attending Physician): The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02751

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clarence Benson Smith, Sr.

2. Date of Death

January 15, 2008

3. Time of Death

7:45 p<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Laurelwood Care Center

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

5. Social Security Number

219-42-5689

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 17, 1946

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Perryville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

405 Reservoir Road

10f. Zip Code

21903

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

Ten Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Carpenter

17. Father's Name (First, Middle, Last)

William Ardie Smith

18. Mother's Name (First, Middle, Maiden Surname)

Irene A. Kenney

19a. Informant's Name/Relationship (Type, Print)

Raymond E. Smith (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

405 Reservoir Road, Perryville, Maryland 21903

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

R.A. Ferris &amp; Co., Inc.

Date

01/17/08

20c. Location - City or Town, State

West Chester, Pennsylvania

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee A. Patterson & Son Funeral Home, P.A.  
Perryville, Maryland 21903-0766

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC COLON CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

054073

29d. Date signed (Month, Day, Year)

JAN 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arlene Stone, MD B17 CITIZENSHIPS CTR NEWCASTLE DE 19720

31. Date filed (Month, Day, Year)

JAN 22 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02752

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Erich H. Selhorst

2. Date of Death

January 18, 2008

3. Time of Death

10:30 P M

4a. Facility Name (If not institution, give street and number)

Sunbridge Nursing Home

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

180-34-4373

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

December 3, 1921

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Earleville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

99 Farmdale Road

10f. Zip Code

21919

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Auto Mechanic

16b. Kind of Business/Industry

Auto

17. Father's Name (First, Middle, Last)

Oskar Friedrich Selhorst

18. Mother's Name (First, Middle, Maiden Sumame)

Amalie Hermann

19a. Informant's Name/Relationship (Type, Print)

Erich R. Selhorst/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

99 Farmdale Road Earleville, Maryland 21919

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

R.T. Foard Funeral Home, P.A.

Date

1-23-08

20c. Location - City or Town, State

Rising Sun, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

R. T. Foard Funeral Home, P.A.  
111 S. Queen Street, Rising Sun, Maryland 2191123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. LUNG CARCINOMA

Due to (or as a consequence of):

b. H/O PROSTATE CARCINOMA

Due to (or as a consequence of):

c. CHRONIC BRONCHITIS AIRWAY DISEASE

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

YEARS

years

year

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

P. V. Noyes M.D.

29c. License number

D0065733

29d. Date signed (Month, Day, Year)

1/21/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

118 NORTH Street, Suite 3B, ELKTON, MD - 21921

31. Date filed (Month, Day, Year)

JAN 22 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



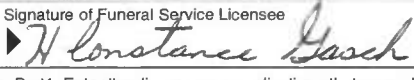
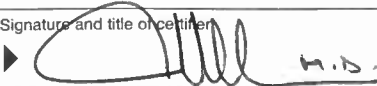

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02753

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Christine Lynne Sullivan</b>  |  |   |  | 2. Date of Death<br>Month <b>1</b> Day <b>13</b> Year <b>2008</b>  |  |   |  | 3. Time of Death<br><b>3:40 P<sup>M</sup></b>  |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>5704 30th Avenue</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Hyattsville, MD</b>   |  |   |  | 4c. County of Death<br><b>Prince George's</b>  |  |  |  |
| 5. Social Security Number<br><b>216-76-2704</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>50</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>2/14/1957</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>                                |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |   |  |  |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Hyattsville</b>  |  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br><b>5704 30th Avenue</b>  |  |   |  | 10f. Zip Code<br><b>20782</b>  |  |   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerical</b>   |  |   |  | 16b. Kind of Business/Industry<br><b>Centers for the Handicapped CHI, Inc</b>                      |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Alex Sullivan</b>  |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Langford</b>  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Paula J. Perry, Sister</b>  |  |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5704 30th Ave., Hyattsville, MD 20782</b> |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Cemetery</b>  |  |   |  | 20c. Location - City or Town, State<br><b>1/19/2008 Brentwood, MD</b>                              |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Gasch's Funeral Home, P.A.</b>  |  |   |  | 4739 Baltimore Ave.<br><b>Hyattsville, MD 20781</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Alzheimer's Disease</b><br>Due to (or as a consequence of):<br><b>Down's Syndrome</b><br>Due to (or as a consequence of):<br><b>Seizure Disorder, Anxiety Disorder, Depression</b><br>Due to (or as a consequence of): |  |   |  |  |  |   |  |  |  |  |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Seizure Disorder, Anxiety Disorder, Depression</b>   |  |   |  |  |  |   |  |  |  |  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  |   |  |  |  |   |  |  |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |  |  |   |  |  |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |  |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.       |  |   |  |  |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D55559</b>   |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>January 14, 2008</b>                                     |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Thomas Edward Maslen, MD 7525 Greenway Center Drive # 316, Greenbelt, MD 20770</b>  |  |   |  |  |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 17 2008</b>  |  |   |  | 32. Registrar's Signature<br>   |  |   |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02754

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Audrey Sutherland

2. Date of Death

January 14, 2008

3. Time of Death

09:00AM

4a. Facility Name (If not institution, give street and number)

2879 Biggs Highway

4b. City, Town, or Location of Death

North East

4c. County of Death

Cecil

5. Social Security Number

218-20-1893

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

8. Date of Birth

May 8, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Cecil

10c. City, Town or Location

North East

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2879 Biggs Highway

10f. Zip Code

21901

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Henry Keen

18. Mother's Name (First, Middle, Maiden Surname)

Lily Preston

19a. Informant's Name/Relationship (Type, Print)

Lisa Noll / Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2879 Biggs Highway, North East, Maryland 21901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harford Memorial Gardens

Date

January 19, 2008

20c. Location - City or Town, State

Aberdeen, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Crouch Funeral Home  
127 South Main Street, North East, Maryland 21901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

relative's house

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

H Farkas, MD

29c. License number

D15314

29d. Date signed (Month, Day, Year)

January 15, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H Farkas, MD Seasons Hospice, 133 N. Bridge St., Elkton, MD

31. Date filed (Month, Day, Year)

JAN 18 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02755

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frank Leroy Savage

2. Date of Death  
Month Day Year  
January 13, 20083. Time of Death  
10:28 PM

4a. Facility Name (If not institution, give street and number)

1433 West Philadelphia Road

4b. City, Town, or Location of Death

North East

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

219-60-7946

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

Nov. 9, 1954

9. Birthplace (State or Foreign  
Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

North East

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1433 West Philadelphia Road

10f. Zip Code

21901

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ NoIf Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Dietary Department

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Frank P. Savage

18. Mother's Name (First, Middle, Maiden Surname)

Gloria Elburn

19a. Informant's Name/Relationship (Type. Print)

Valerie McMullen / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

264 Harrisville Road, Colora, Maryland 21917

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

North East Methodist

Date

January 18, 2008

20c. Location - City or Town, State

North East, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Crouch Funeral Home

127 South Main Street, North East, Maryland 21901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic Prostate Cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

unknown

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0035653

29d. Date signed (Month, Day, Year)

01/15/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite 104

Dr. Martha A. Hosford-Skapof, M.D., 111 High Street, Elkton, Maryland 21921

31. Date filed (Month, Day, Year)

JAN 18 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02756

1- For  
State  
Registrar

|   |  |   |   |  |  |   |  |  |
|---|--|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Margaret P SHEPHERD</b>   |   |   |  | 2. Date of Death<br>Month <b>January</b> Day <b>16</b> , Year <b>2008</b>  |   | 3. Time of Death<br><b>7:00 A M</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>   |   | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>346-14-5184</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>11-27-1923</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Illinois</b>  |   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Anne Arundel</b>   |   | 10c. City, Town or Location<br><b>Lothian</b>  |  |
| To Be Completed by<br>Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>5808 Greenock Road</b>   |  | 10f. Zip Code<br><b>20711</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>teacher</b>   |  | 16b. Kind of Business/Industry<br><b>public school</b>   |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Malcolm Alan Poole</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lucy Campbell Conway</b>   |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>David S. Shepherd, son</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>100 Alwoodley, Williamsburg, VA 23188</b>  |   |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory 1-17-08</b>   |  | 20c. Location - City or Town, State<br><b>Alexandria, VA</b>   |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>William B. G...</b>  |   | 22. Name and Address of Facility<br><b>Rausch Funeral Home, P.A.<br/>8325 Mt. Harmony Lane, Owings, MD 20736</b>  |  |  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Vascular collapse -</b><br>Due to (or as a consequence of):<br>b. <b>Bleeding gastro intestinal - CHF</b><br>Due to (or as a consequence of):<br>c. <b>Atrial fibrillation - cardiomyopathy</b><br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>hours</b><br><b>hours</b><br><b>years.</b> |   |   |  |  |   |  |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death<br><input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  |   | 23d. Date of delivery<br>Month <b>1</b> Day <b>16</b> Year <b>2008</b>   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes type I</b><br><b>PVD</b>   |   |   |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>Michele Smassa-Gordon</b>   |  |   |   | 29c. License number<br><b>D0031998</b>                                       |  | 29d. Date signed (Month, Day, Year)<br><b>1-16-2008</b>                                     |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michele Smassa-Gordon 116 Defense Hwy St 400 Annapolis MD 21401</b>  |  |   |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 18 2008</b>   |  | 32. Registrar's Signature<br><b>James D. Spotts</b>   |   |  |  |   |  |  |

Baltimore, Maryland 21215-0036

Baltimore, Maryland 21215-0036  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02757

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mark Augustus Sanders

2. Date of Death

January 13, 2008

3. Time of Death

6:50 p<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Carroll Hospice Dove House

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

218-24-9936

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 3, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Taneytown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6218 Taneytown Pike

10f. Zip Code

21787

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

11

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Dairy Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

James Casper Sanders

18. Mother's Name (First, Middle, Maiden Surname)

Marie Edna McMaster

19a. Informant's Name/Relationship (Type, Print)

Helen L. Sanders, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6218 Taneytown Pike, Taneytown, MD 21787

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Joseph's Cemetery 1/17/2008

Date

20c. Location - City or Town, State

Taneytown, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Myers-Durbin Funeral Home  
136 E. Baltimore Street, Taneytown, MD 2178723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Recurrent Aspiration Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Advanced dementia

Due to (or as a consequence of):

c. Parkinson's disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Colon Cancer.

Non Insulin dependent diabetes

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Hospice.

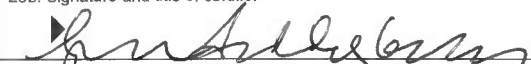
27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

039502 M-13

29d. Date signed (Month, Day, Year)

1/14/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syed S Hosain MD 4471 East Main Street Westminster MD 21157

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 15 2008

32. Registrar's Signature



Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
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To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Amend Item 8 per Dr., 8882, 08/28/08dhb  
 Amend Item 9 per Dr., 8876, 02/16/08dhb  
 Amend Item 3 per Dr., 8876, 02/16/08dhb

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene  
 Certificate of Death

Reg. No.

2008 02758

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, #3 Wicomico

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>SYLVESTER JUNIOR SETH</b>  |  | 2. Date of Death<br>Month <b>01</b> - Day <b>13</b> - Year <b>08</b>  |  | 3. Time of Death<br><b>8:53 a M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>5308 Eastwood Circle</b>   |  | 4b. City, Town, or Location of Death  |  | 4c. County of Death<br><b>WICOMICO Co.</b>   |  |
| 5. Social Security Number<br><b>222-61-9151</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>33</b> Yrs.   |  |
| 8. Date of Birth<br>Month <b>08</b> / Day <b>13</b> / Year <b>1974</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>WICOMICO</b>  |  | 10c. City, Town or Location<br><b>SALISBURY</b>  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |
| 10e. Street and Number<br><b>5308 Eastwood Circle</b>   |  | 10f. Zip Code<br><b>21804</b>   |  | 10g. Citizen of What Country?<br><b>U S A</b>  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>CAB DRIVER</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CAB DRIVER</b>  |  | 16b. Kind of Business/Industry<br><b>BAILEY'S TAXI SERVICE</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>SYLVESTER Tilghman</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VELMA TILGHMAN</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Velma Tilghman mother</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14107 ARVEY Rd LAUREL, DE</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Federal Hill Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>1-19-08 Federalsburg Md.</b>   |  |
| 21. Signature of Funeral Service Licenses<br><b>[Signature]</b>   |  | 22. Name and Address of Facility<br><b>BENNIE SMITH FTH 917 W. ISABELLA ST. SALISBURY, MD 21801</b>   |  |  |  |
| 23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or organ failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Acquired immune deficiency</b>   |  |   |  |  |  |
| 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.  |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  | 29c. License number<br><b>DOB 25-674</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>1/16/08</b>   |  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J A Cooley, 1346 S. Division St, Salisbury, md 21801</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 17 2008</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02760

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |  |  |  |   |  |  |   |   |  |
|---|---|--|--|--|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Polly W. Thompson</b>  |  |  |  | 2. Date of Death<br>Month <b>January</b> Day <b>15</b> Year <b>2008</b>   |  |  |   | 3. Time of Death<br><b>5:10 P<sup>M</sup></b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Sunbridge Care &amp; Rehab</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Elkton</b>   |  |  |   | 4c. County of Death<br><b>Cecil</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>222-50-9023</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>98</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>May 25, 1909</b> |   | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>   |  |
|   | Usual Residence of Decedent   |  |  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Cecil</b>                                |   | 10c. City, Town or Location<br><b>Elkton</b>  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>1 Price Drive</b>  |  |  |   | 10f. Zip Code<br><b>21921</b>   |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)   |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  |  |   | 17. Father's Name (First, Middle, Last)<br><b>Columbus Edward Morean</b>  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sallie Frances Evans</b>  |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Clarence W. Thompson, Jr./son</b>  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>419 Vernon Woods, Glen Mills, PA 19342</b>  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gracelawn Memorial Park 1-22-08</b>  |  |  |   | 20c. Location - City or Town, State<br><b>New Castle, Delaware</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Richard L. Goodie</i>   |  |  |  | 22. Name and Address of Facility<br><b>R. T. Foard Funeral Home, P.A.<br/>318 George Street, Chesapeake City, MD 21915</b>  |  |  |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>FAILURE THINE</b><br><b>DYSPHAGIA</b><br><b>DIABETES mellitus type II</b> |  |
|   | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |   | 23d. Date of delivery<br>Month Day Year   |  |
|   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined    |  |
| 28a. Date of Injury (Month, Day, Year)  |   |  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |
| 29b. Signature and title of certifier<br><i>P. V. Narayana MD</i>   |   |  |  | 29c. License number<br><b>D0065733</b>                                       |   |  |  | 29d. Date signed (Month, Day, Year)<br><b>1/15/08</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Narayana Pula, MD 118 North Street, Elkton, MD 21921</b> |   |  |  | 31. Date filed (Month, Day, Year)<br><b>JAN 22 2008</b>                      |   |  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02761

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edna K. Thrift

2. Date of Death  
Month Day Year

January 14 2008

3. Time of Death

23:46p M

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

Funeral  
Director

5. Social Security Number

577-30-5519

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

81

8. Date of Birth

10/10/1926

9. Birthplace (State or Foreign Country)

Arkansas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Solomons

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11740 Asbury Circle #117AL

10f. Zip Code

20688

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Thrifty Ironworks, Inc.

17. Father's Name (First, Middle, Last)

Monroe James Kelly

18. Mother's Name (First, Middle, Maiden Surname)

Edith Kilgore

19a. Informant's Name/Relationship (Type. Print)

Christine Marrangoni - Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1850 Bright Lane, Owings, MD 20736

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

01/19/2008

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

A. Miller

22. Name and Address of Facility

Fort Lincoln Funeral Home  
3401 Bladensburg Rd., Brentwood, MD 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Severe chronic obstructive pulmonary disease

Due to (or as a consequence of):

years

b. Congestive heart failure

Due to (or as a consequence of):

years

c. Ischemic cardiomyopathy

Due to (or as a consequence of):

years

d. Coronary artery disease

Due to (or as a consequence of):

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Hypothyroidism

Intermittent atrial flutter

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Miller, MD

29c. License number

060390

29d. Date signed (Month, Day, Year)

1/15/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADEEB JABER 100 HOSPITAL RD., PRINCE FREDERICK, MD 20678

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

James B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02762

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

MAVIS THOMSON

2. Date of Death

Month

Day

Year

1 15 2008

3. Time of Death

0530 AM

4a. Facility Name (If not institution, give street and number)

BALTIMORE WASHINGTON CENTER

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

028-14-4588

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 8, 1925

9. Birthplace (State or Foreign Country)

Mass.

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1829 Crofton Parkway Apt. D

10f. Zip Code

21114

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Personell Specialist

16b. Kind of Business/Industry

U.S. Govt.

17. Father's Name (First, Middle, Last)

John Powell Thomson

18. Mother's Name (First, Middle, Maiden Surname)

Martha MacFarlane

19a. Informant's Name/Relationship (Type, Print)

Kerry G. Thomson / nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Box 662 Tuckahoe, NJ 08250

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 01/15/08

Date

20c. Location - City or Town, State

Alexandria, VA.

21. Signature of Funeral Service Licensee

Brian Powell

22. Name and Address of Facility

Beall Funeral Home

6512 NW Crain Hwy. Bowie, MD. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. AORTIC DISSECTION

Due to (or as a consequence of):

b. HYPERTENSION

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David A. Vitarello MD

29c. License number

D64307

29d. Date signed (Month, Day, Year)

1/15/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID A. VITARELLO, MD 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

Brian Powell

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02763

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |   |   |                                 |  |  |  |  |  |  |
|---|---|---|---|---------------------------------|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Irene Dolores Tanavage</b>   |   |   |                                 |  |  | 2. Date of Death<br>Month Day Year<br><b>1/14/2008</b>   |  | 3. Time of Death<br><b>6:30 a.m.</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Prince George's Hospital</b>   |   |   |                                 | 4b. City, Town, or Location of Death<br><b>Cheverly</b>  |  | 4c. County of Death<br><b>Prince George's</b>  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>202-26-0888</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                                 | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>11/18/1933</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Nanticoke, PA</b>                                   |  |
|   | Usual Residence of Decedent   |   |   |                                 |  |  |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Prince George's</b>   |                                 | 10c. City, Town or Location<br><b>Hyattsville</b>  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>6804 Fairwood Road</b>   |   |   |                                 | 10f. Zip Code<br><b>20784</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   |   |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Stanley F. Ruda</b>   |   |   |                                 |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Piniasek</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Simon J. Tanavage, Husband</b>   |   |   |                                 |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6804 Fairwood Rd., Hyattsville, MD 20784</b> |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |                                 | Date<br><b>1/17/2008</b>   |  | 20c. Location - City or Town, State<br><b>Alexandria, VA</b>   |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Claudette Dask</i>  |   |   |                                 |  |  | 22. Name and Address of Facility<br><b>Gasch's Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, MD 20781</b>                                  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Aortic Aneurysm</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |                                 |  |  |  |  |  |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death<br>9 <input type="checkbox"/> Unknown |                                 |  |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>   |   |   |   |                                 |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |                                 |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                                 |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b> |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                                 |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |                                 |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Reva Gill MD</i>  |   |   |   |                                 |  | 29c. License number<br><b>D0050951</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>1/15/08</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Reva Gill, MD 6510 Kenilworth Ave. Suite 2400, Riverdale, MD 20737</b>   |   |   |   |                                 |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 17 2008</b>   |   | 32. Registrar's Signature<br><i>Reva Gill</i>   |   |                                 |  |  |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, this Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02764

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary D Twilley

2. Date of Death  
Month Day Year  
January 15, 20083. Time of Death  
1:00 A MFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Harrison Senior Living

4b. City, Town, or Location of Death

Snow Hill

4c. County of Death

Worcester

5. Social Security Number

214-46-4561

6. Sex  
☒ M ☐ F

7. Age (In yrs. last birthday)

95

8. Date of Birth (Month, Day, Year)

Dec. 14, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

Pittsville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9049 Gumboro Road

10f. Zip Code

21850

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charlton

18. Mother's Name (First, Middle, Maiden Surname)

Dryden

Della

Givens

19a. Informant's Name/Relationship (Type, Print)

Grace T. Disharoon- daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9049 Gumboro Road Pittsville, MD 21850

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pittsville Cemetery

Date

1/18/2008

20c. Location - City or Town, State

Pittsville, MD

21. Signature of Funeral Service Licensee

*Malissa Haug Blake*

22. Name and Address of Facility

Bounds Funeral Home

705 E Main St. Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown☐ Ectopic pregnancy☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined☐ Pending investigation☐ Could not be determined☐ Pending investigation☐ Could not be determined☐ Pending investigation☐ Could not be determined☐ Pending investigation☐ Could not be determined☐ Pending investigation☐ Could not be determined☐ Pending investigation☐ Could not be determined☐ Pending investigation☐ Could not be determined☐ Pending investigation☐ Could not be determined☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*SARAD R. BARAL*

29c. License number

D 54422

29d. Date signed (Month, Day, Year)

1-15-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1604 - Market St. Pocomoke, MD 21851

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

*John H. Smith*

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02765

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Barry Verdier

2. Date of Death

Month

Day

Year

Jan.

24

2008

3. Time of Death

10:30<sup>AM</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

12968 Greensburg Road

4b. City, Town, or Location of Death

Smithsburg

4c. County of Death

Washington

5. Social Security Number

220-54-3901

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 7, 1950

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Smithsburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12968 Greensburg Road

10f. Zip Code

21783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Richard Earl Verdier

18. Mother's Name (First, Middle, Maiden Surname)

Sadie Isabel Lohman

19a. Informant's Name/Relationship (Type, Print)

Brian M. Verdier (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12968 Greensburg Rd. Smithsburg, Maryland 21783

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Science Care

Date

January

29, 2008

20c. Location - City or Town, State

Aurora, Colorado

21. Signature of Funeral Service Licensee

J. L. Davis M01414

22. Name and Address of Facility

J.L. Davis Funeral Home

12525 Bradbury Ave. Smithsburg, Maryland 21783

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. liver metastatic cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. unknown primary site

Due to (or as a consequence of):

1 year

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

M

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hind Hamdan, MD; 1130 OPAL CT.; Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

FEB 01 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 88

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02766

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br>James S. Wilson   |  |  |  | 2. Date of Death<br>Month Day Year<br>January 13 2008  |  | 3. Time of Death<br>1657 M  |  |
| 4a. Facility Name (If not institution, give street and number)<br>Anne Arundel Medical Center   |  |  |  | 4b. City, Town, or Location of Death<br>Annapolis  |  | 4c. County of Death<br>Anne Arundel   |  |
| 5. Social Security Number<br>149-14 9916  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>80 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>April 15, 1927                       |  |
| 9. Birthplace (State or Foreign Country)<br>New Jersey  |  |  |  |  |  |   |  |
| 10a. State<br>Maryland  |  |  |  | 10b. County<br>Prince George's   |  | 10c. City, Town or Location<br>Bowie  |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |  |  |   |  |
| 10e. Street and Number<br>16010 Excalibur Road, #D206   |  |  |  | 10f. Zip Code<br>20716   |  | 10g. Citizen of What Country?<br>U.S.A.                                     |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: African-American |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+) 4   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Public Administration   |  | 16b. Kind of Business/Industry<br>Local Government                          |  |
| 17. Father's Name (First, Middle, Last)<br>James Sherwood Wilson, Sr.   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Virginia Jones  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Phyllis C. Wilson - Wife  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>16010 Excalibur Road, #D206, Bowie, Maryland 20716  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery  |  | Date<br>01/18/2008   |  | 20c. Location - City or Town, State<br>Silver Spring, Maryland              |  |
| 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br>Hines-Rinaldi Funeral Home, Inc.<br>11800 New Hampshire Avenue, Silver Spring, Maryland 20904  |  |   |  |

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>URINARY TRACT INFECTED</u><br>Due to (or as a consequence of):   |  |   |  | Approximate Interval Between Onset and Death   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):  |  |   |  |  |  |
| c. Due to (or as a consequence of):  |  |   |  |  |  |
| d. Due to (or as a consequence of):  |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)                                       |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>STROKE</u>  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br>D39037   |  | 29d. Date signed (Month, Day, Year)<br>01-13-2008  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DS Mottish, 2001 MEDICAL PARKWAY ANNAPOLIS MD 21401  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JAN 17 2008   |  | 32. Registrar's Signature<br>   |  |  |  |

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02767

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Melvin Wrublewski

2. Date of Death

January 21, 2008

3. Time of Death

06:00 AM

4a. Facility Name (If not institution, give street and number)

803 A Almond Court

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

056-22-7478

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 1, 1929

9. Birthplace (State or Foreign Country)

Canada

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

803 A Almond Court

10f. Zip Code

21014-2677

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1950-1952

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrical Engineer

16b. Kind of Business/Industry

Civil Service

17. Father's Name (First, Middle, Last)

Roy Wrublewski

18. Mother's Name (First, Middle, Maiden Surname)

Jessie Truss

19a. Informant's Name/Relationship (Type, Print)

Charlotte L. Bowman (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

48 Highview Road, Conowingo, Maryland 21918

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

R.A. Ferris &amp; Co

Date

1/22/2008

20c. Location - City or Town, State

West Chester, PA

21. Signature of Funeral Service Licensee

Ara C. Zellman

22. Name and Address of Facility

Zellman Funeral Home, P.A.  
123 S. Washington St. Havre de Grace, MD 21078

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Bladder Carcinoma

Approximate Interval Between Onset and Death

10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Vincent A. Giminardo

29c. License number

H0054439

29d. Date signed (Month, Day, Year)

January 21, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vincent A. Giminardo 4B North Avenue \*310 Bel Air, MD 21014

31. Date filed (Month, Day, Year)

JAN 22 2008

32. Registrar's Signature

John B. Spotts

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend 28d&amp;28e, per ME, g876, 2/28/08 Certificate of Death

Reg. No.

2008 02768

|  |   |   |  |  |                                      |  |
|--|---|---|--|--|--------------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Roger H. Welch Sr.                                      |   | 2. Date of Death<br>Month Day Year<br>January 14 2008  |  | 3. Time of Death<br>1650 M           |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Peninsula Regional Medical Center |   | 4b. City, Town, or Location of Death<br>Salisbury  |  | 4c. County of Death<br>Wicomico      |  |
| Funeral<br>Director  | 5. Social Security Number<br>214-42-8626  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>64 |  |
|  | 8. Date of Birth (Month, Day, Year)<br>12/30/1943   |   | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |                                      |  |
| Usual Residence of Decedent  |   |   |  |  |                                      |  |
| 10a. State<br>Maryland   |   | 10b. County<br>Wicomico   |  | 10c. City, Town or Location<br>Parsonsburg   |                                      | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 10e. Street and Number<br>31348 Zion Road  |   | 10f. Zip Code<br>21849  |  | 10g. Citizen of What Country?<br>USA   |                                      |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: white   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 4+  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>carpentry instructor   |  | 16b. Kind of Business/Industry<br>education  |                                      |  |
| 17. Father's Name (First, Middle, Last)<br>Wilson H. Welch   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Nannie Moore  |  |                                      |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Charlotte Welch/wife   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>31348 Zion Rd., Parsonsburg, MD 21849 |  |                                      |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Wicomico Memorial Park  |  | Date<br>1/18/08  |                                      | 20c. Location - City or Town, State<br>Salisbury, MD   |
| 21. Signature of Funeral Service Licensee<br>Holloway Funeral Home Professional Association  |   | 22. Name and Address of Facility<br>501 Snow Hill Rd., Salisbury, MD 21804  |  |  |                                      |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. intracranial hemorrhage<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br>1 day |   |   |  |  |                                      |  |
| 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year               |   |   |  |  |                                      |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>1) fall  |   |   |  |  |                                      | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |                                      |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                      |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)<br>1/12/08  |  | 28b. Time of Injury<br>1200 M  |                                      | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br>yard   |   | 28d. Describe how injury occurred<br>ladder fell  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>31350 ZION RD PARSONSBURG, MD  |                                      |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |  |  |                                      |  |
| 29b. Signature and title of certifier<br>LIN CHIN  |   | 29c. License number<br>H50497   |  | 29d. Date signed (Month, Day, Year)<br>1/15/08   |                                      |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>560 Riverside Dr Suite A 200 Salisbury MD 21801  |   |   |  |  |                                      |  |
| 31. Date filed (Month, Day, Year)<br>JAN 18 2008   |   | 32. Registrar's Signature<br>[Signature]  |  |  |                                      |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02769

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Aline Praither Williams

2. Date of Death

January 15 2008

3. Time of Death

5:30a M

4a. Facility Name (If not institution, give street and number)

Manor Care Nursing Home

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

577-24-9931

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

100 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

07/17/1907

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

D.C.

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

140 Longfellow Street, N.W.

10f. Zip Code

20011

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Rezin Praither

18. Mother's Name (First, Middle, Maiden Surname)

Ella Butcher

19a. Informant's Name/Relationship (Type, Print)

E. Marlene Tolson - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

706 Nicholson St., N.W., Washington, DC 20011

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery 01/19/2008 Brentwood, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*Joseph Montgomery - Chief Clerk*

22. Name and Address of Facility

Fort Lincoln Funeral Home  
3401 Bladensburg Rd., Brentwood, MD 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Dementia*  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Dehydration**Coronary Artery Disease*

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Darryl Hill*

29c. License number

0053235

29d. Date signed (Month, Day, Year)

1/16/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Darryl Hill 13635 Baltimore Avenue Laurel, MD 20707

State Registrar

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

*James D. Smith*

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02770

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eileen Elizabeth Weetman

2. Date of Death  
Month Day Year

JAN 9 2008

3. Time of Death  
1457

4a. Facility Name (If not institution, give street and number)

Anne Arundel Gen Hosp

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

A #

Funeral  
Director

5. Social Security Number

577-12-0847

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

11/16/1920

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1010 Simsbury Court

10f. Zip Code

21114

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerical

16b. Kind of Business/Industry

C & P

17. Father's Name (First, Middle, Last)

Walter A. Walker

18. Mother's Name (First, Middle, Maiden Surname)

Marguerite Louise Walker

19a. Informant's Name/Relationship (Type, Print)

Carol Lee, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1010 Simsbury Ct., Crofton, MD 21114

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

1/12/08

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

Ernest G. Colvin II

22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Ave.  
Hyattsville, MD 20782

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

COPD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hip Fracture

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28a. Date of Injury (Month, Day, Year)

12/2/07

28b. Time of Injury

UNK M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Fell from Walker

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Crofton, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William P. Jones, MD

29c. License number

DO6054

29d. Date signed (Month, Day, Year)

1/10/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. Jones, MD 695 America Ct 21035

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

Don B. Spivey

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02771

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Maury Werth

2. Date of Death

January 19 2008

3. Time of Death

12:18 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

224-50-5646

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90 Yrs.

8. Date of Birth

If Under 1 Year If Under 24 Hrs.

8. Date of Birth (Month, Day, Year)

Sept. 15, 1917

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Williamsport

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16505 Virginia Avenue

10f. Zip Code

21795

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Captain

16b. Kind of Business/Industry

Military

17. Father's Name (First, Middle, Last)

James Rhodes Werth

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Bogardus

19a. Informant's Name/Relationship (Type, Print)

James A. Werth - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

153 Crawford Parkway Portsmouth, Virginia 23704

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Rose Hill Cemetery

Date

Jan. 23, 2008

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Osborne Funeral Home, P.A. 21795  
425 S. Conococheague St. Williamsport, Maryland23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. VENTRICULAR TACHYCARDIA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

MINUTES

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D17067

29d. Date signed (Month, Day, Year)

1/19/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEPHEN E. METZGER, MD 13424 P2 Ave, STE 101 Hagerstown, Md 21742

31. Date filed (Month, Day, Year)

JAN 23 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For Amend Item #5 State of Maryland / Department of Health and Mental Hygiene  
1- State Registrar WCHD/SH 1/23/08 per FH Certificate of Death

Reg. No. 2008 02772

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Maurice Wilbur WALLECH, Jr.</b>   |  | 2. Date of Death<br>Month <b>January</b> Day <b>20</b> Year <b>2008</b>  |   | 3. Time of Death<br><b>12:14 PM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Washington County Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>  |   | 4c. County of Death<br><b>Washington</b>   |  |
| 5. Social Security Number<br><b>220 42 5673</b><br><del>221 42 5675</del>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>Jan 26 1946</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Washington</b>   |   | 10c. City, Town or Location<br><b>Hagerstown</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>610 George Street</b>   |   | 10f. Zip Code<br><b>21740</b>  |  |
| 10g. Citizen of What Country?<br><b>USA</b>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br><b>10</b>   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Technical Engineer</b>   |  | 16b. Kind of Business/Industry<br><b>City Government</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>Maurice Wilbur Wallech, Sr.</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Louise Rowe</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>June Wallech - Wife</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>610 George Street, Hagerstown, Maryland 21740</b>  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Lawn Mem. Park</b>  |   | 20c. Location - City or Town, State<br><b>Hagerstown, Maryland</b>   |  |
| 20d. Date<br><b>1/24/08</b>  |  | 21. Signature of Funeral Service Licenses<br><i>[Signature]</i>  |   | 22. Name and Address of Facility<br><b>Minnich Funeral Home<br/>415 E. Wilson Blvd. Hagerstown, Maryland 21740</b>   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on this line.<br><b>Sudden death</b>   |  |  |   |  |  |
| 23b. Immediate Cause (Final disease or condition resulting in death)<br><b>Respiratory insufficiency</b>   |  |  |   |  |  |
| 23c. Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>S/P acute respiratory failure</b>  |  |  |   |  |  |
| 23d. Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Acute renal failure</b>  |  |  |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)  |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Swallowing dysfunction with aspiration<br/>chronic obstructive lung disease<br/>Sepsis pneumonia</b>  |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)<br><b>M</b>  |   | 28b. Time of Injury<br><b>1</b> Yes <input type="checkbox"/> No  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |  | 29c. License number<br><b>DC041131</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>Jan - 20, 2007</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JERRY L. CORRELLS, MD 1124 Opel Court, Hagerstown MD 21740</b>  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 22 2008</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |  |

CH-5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02773

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Lois Irene Amos

2. Date of Death

January 29, 2008

3. Time of Death

10:55A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Charlestown

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

215-22-3944

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

8. Date of Birth

4/17/1926

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

709 Maiden Choice Lane, S120

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own home

17. Father's Name (First, Middle, Last)

Edward Burget

18. Mother's Name (First, Middle, Maiden Surname)

Frances Franz

19a. Informant's Name/Relationship (Type, Print)

William C. Amos / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9255 Hobnail Court, Columbia, MD 21045-4006

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory

Date

2/4/2008

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Richard S. Sinder

22. Name and Address of Facility

Hubbard Funeral Home, Inc.  
4107 Wilkens Avenue, Baltimore, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Chronic obstructive lung disease

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Phillip Stone, MD

29c. License number

D47009

29d. Date signed (Month, Day, Year)

January 29, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Phillip Stone 711 Maiden Choice Lane Baltimore MD 21228

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02774

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Rebekah Bain

2. Date of Death  
Month Day Year  
Jan. 24, 20083. Time of Death  
10:00A.M.Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Levindale Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

214-26-8841

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 21, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2907 Woodland Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4 years

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Social Worker

16b. Kind of Business/Industry

Baltimore City

17. Father's Name (First, Middle, Last)

James Logan Jenkins, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Adah Killion

19a. Informant's Name/Relationship (Type, Print)

Logan Mitchell, Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3324 Ingleside Avenue Baltimore, Maryland 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arbutus Memorial Park

Date

2/17/08

20c. Location - City or Town, State

Arbutus, Maryland

21. Signature of Funeral Service Licensee

Serry Harris

22. Name and Address of Facility

Chatman-Harris Funeral Home

5240 Reisterstown Rd Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia - multifactorial

Due to (or as a consequence of):

Sequentially list conditions,

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Type II Diabetes Mellitus,  
Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. M. L. M.

29c. License number

033943

29d. Date signed (Month, Day, Year)

01/24/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan Bey

Levindale 2734 W Belvedere 21215

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1-

For  
State  
Registrar

Amend 8,10e,15,22,per H, 88/6, 2/4/08

## Certificate of Death

Reg. No. 2008 02775

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Frank Augustus Bell

2. Date of Death

Jan. 25, 2008

3. Time of Death

2110 M

4a. Facility Name (If not institution, give street and number)

Carroll Hospital Center

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

220-18-4770

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

96

8. Date of Birth

Mar. 9, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Baltimore10c. City, Town or Location  
Reisterstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

304 Cantata Court Apt. 212

10f. Zip Code

21136

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: Black15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Horseman

16b. Kind of Business/Industry

Black Rock Farms

17. Father's Name (First, Middle, Last)

Herman Bell

18. Mother's Name (First, Middle, Maiden Surname)

Anna Bessie Derricks

19a. Informant's Name/Relationship (Type, Print)

Anna Bell/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

304 Cantata Court Apt. 212 Reisterstown, Md 21136

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gough U.M. Methodist Ch. Cem.

20c. Location - City or Town, State

Cockeysville, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Chatman-Harris Funeral Home  
5240 Reisterstown, Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. DYS PHAG IA

Due to (or as a consequence of):

b. C. V. A.

Due to (or as a consequence of):

c. Chronic Atrial Fibrillation

Due to (or as a consequence of):

d. C. H. F.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-0054218

29d. Date signed (Month, Day, Year)

01-28-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. RAMAN B KANERIA, 349 Maleahm drive, Westminster MD

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend 20b, per Fh, g876, 2/4/08 TT Certificate of Death

Reg. No. 2008 02776

|  |   |   |   |  |  |  |   |  |
|--|---|---|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>George Brown</b>   |   |   |  | 2. Date of Death<br>Month: <b>02</b> Day: <b>02</b> Year: <b>2008</b>  |  | 3. Time of Death<br><b>0929 AM</b>                                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>John's Hopkins Bayview</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>  |  | 4c. County of Death<br><b>Baltimore City</b>                            |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-05-0374</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><b>10/31/1920</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                    |
|  | Usual Residence of Decedent   |   |   |  |  |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|  | 10e. Street and Number<br><b>1336 SHERWOOD AVENUE</b>   |   |   |  | 10f. Zip Code<br><b>21239</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10TH GRADE</b> College (1-4 or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MACHINIST</b>  |  | 16b. Kind of Business/Industry<br><b>WESTERN ELECTRIC</b>               |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>CHARLES BROWN</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>NETTIE BEYER</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>DOROTHY DIMICK/DAUGHTER</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7300 KIRTLEY ROAD BALTIMORE, MD 21224</b>  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>DULANEY VALLEY MEM. GARDENS</b>  |  | Date<br><b>2/6/2008</b>  |  | 20c. Location - City or Town, State<br><b>TIMONIUM, MD</b>              |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Heath Hay-Larson</i>  |   |   |  | 22. Name and Address of Facility<br><b>THE JOHNSON FUNERAL HOME, P.A.<br/>8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Aspiration Pneumonia</b><br>Due to (or as a consequence of):<br>b. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>c. <b>Hypertension</b><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |   |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month: Day: Year:                              |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M                         |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |   | 28d. Describe how injury occurred                |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br><i>David A. Harrison MD</i>   |   |   |   | 29c. License number<br><b>00059744</b>           |  | 29d. Date signed (Month, Day, Year)<br><b>02/02/2008</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David A. Harrison MD Dept of Emergency Medicine JHBM 4940 Eastern Ave Baltimore</b>   |   |   |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b>  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |  |   |  |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2008 02777

1- For State  
Registrar

Physician/  
Medical Examiner

|  |  |   |  |                                     |  |
|--|--|---|--|-------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Ryan Keith Bell</b> |  | 2. Date of Death<br>Month Day Year<br><b>January 26, 2008</b> |  | 3. Time of Death<br><b>2151 hrs</b> |  |
|--|--|---|--|-------------------------------------|--|

Funeral  
Director

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 4a. Facility Name (if not institution, give street and number)<br><b>Laurel Regional Hospital</b> |  | 4b. City, Town, or Location of Death<br><b>Laurel</b> |  | 4c. County of Death<br><b>Prince George's</b> |  |
|---|--|---|--|---|--|

|   |  |  |  |  |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|
| 5. Social Security Number<br><b>287-74-5385</b> |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>33</b> Yrs. |  | 8. Date of Birth (MM/DD/YYYY)<br><b>3-15-1974</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b> |  |
|---|--|--|--|--|--|---|--|---|--|

Usual Residence of Decedent

|                         |  |                                    |  |   |  |  |  |
|-------------------------|--|------------------------------------|--|---|--|--|--|
| 10a. State<br><b>MD</b> |  | 10b. County<br><b>Anne Arundel</b> |  | 10c. City, Town or Location<br><b>Ft. Meade</b> |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|-------------------------|--|------------------------------------|--|---|--|--|--|

|   |  |                               |  |   |  |
|---|--|-------------------------------|--|---|--|
| 10e. Street and Number<br><b>8127 A Packard Ct.</b> |  | 10f. Zip Code<br><b>20755</b> |  | 10g. Citizen of What Country?<br><b>United States</b> |  |
|---|--|-------------------------------|--|---|--|

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1996-2008</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
|--|--|--|--|---|--|---|--|

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b><br>Elementary/Secondary (0-12) College (1-4 or 5+) |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Instructor</b> |  | 16b. Kind of Business/Industry<br><b>U. S. Navy</b> |  |
|---|--|--|--|---|--|

|  |  |  |  |
|--|--|--|--|
| 17. Father's Name (First, Middle, Last)<br><b>Calvin Smith</b> |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Angeria Bell</b> |  |
|--|--|--|--|

|   |  |  |  |
|---|--|--|--|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Hisayo Bell / Wife</b> |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8127 A Packard Ct. Ft. Meade, Maryland 20755</b> |  |
|---|--|--|--|

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other Specify: |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>W. Arundel Crematory</b> |  | 20c. Location - City or Town, State<br><b>2/6/2008 Odenton, Maryland</b> |  |
|--|--|---|--|--|--|

|   |  |   |  |
|---|--|---|--|
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i> |  | 22. Name and Address of Facility<br><b>Donaldson Funeral Home &amp; Crematory, P.A.<br/>1411 Annapolis Road Odenton, Maryland 21113</b> |  |
|---|--|---|--|

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

|  |  |  |
|--|--|--|
| Immediate Cause (Final disease or condition resulting in death)<br><b>a. Hypertensive atherosclerotic cardiovascular disease</b> |  | Approximate Interval Between Onset and Death |
| Due to (or as a consequence of):   |  |  |
| Due to (or as a consequence of):   |  |  |
| Due to (or as a consequence of):   |  |  |

|   |  |
|---|--|
| <input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED<br><b>#23a, 27, per ME, g877 3/10/08 TT</b> |  |
|---|--|

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year |  |
|---|--|---|--|---|--|

|  |  |  |  |
|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|--|--|--|--|

|   |  |  |  |
|---|--|--|--|
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|---|--|--|--|

|   |  |  |  |
|---|--|--|--|
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other: |  |
|---|--|--|--|

|  |  |  |  |                     |  |   |  |  |  |
|--|--|--|--|---------------------|--|---|--|--|--|
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |                     |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |

|   |  |
|---|--|
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |
|---|--|

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 29b. Signature and title of certifier<br><i>[Signature]</i> |  | 29c. License number<br><b>O.C.M.E.</b> |  | 29d. Date signed (Month, Day, Year)<br><b>January 27, 2008</b> |  |
|---|--|--|--|--|--|

|  |  |
|--|--|
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b> |  |
|--|--|

|   |  |   |  |
|---|--|---|--|
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b> |  | 32. Registrar's Signature<br><i>[Signature]</i> |  |
|---|--|---|--|

State  
Registrar

Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02778

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Douglas Barnes Sr.

2. Date of Death  
Month Day Year

January 28, 2008 3:53 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

5. Social Security Number

267-50-8719

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

8. Date of Birth  
(Month, Day, Year)

Jan. 29, 1937

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6108 Bison Court

10f. Zip Code

20603

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1954  
195713. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Painter

16b. Kind of Business/Industry

Pvt.

17. Father's Name (First, Middle, Last)

William Henry Barnes

18. Mother's Name (First, Middle, Maiden Surname)

Clara Mobley Bell

19a. Informant's Name/Relationship (Type, Print)

Douglas Barnes Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3079 Heathcote Road  
Waldorf, MD 20602

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Howard University

Date

1/28/08

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Austin Royster Funeral Home

3821 14th Street, NW, Washington, DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Ischemic heart disease  
Due to (or as a consequence of):b. Chronic obstructive airway disease  
Due to (or as a consequence of):c. Heart Ca.  
Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Yahia M. Tagouri

29c. License number

50883

29d. Date signed (Month, Day, Year)

1/28/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yahia Tagouri MD 25500 Pt. Lookout Rd. Leonardtown, Md.

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

20650

State  
RegistrarDouglas Barnes  
Baltimore, Maryland 21215-0036To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02779

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Larry Wilson Bobo

2. Date of Death

Month

Day

Year

Time of Death

2330 M

4a. Facility Name (If not institution, give street and number)

WMHS Braddock Campus

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegheny

Funeral  
Director

5. Social Security Number

233 84 1072

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

8. Date of Birth (Month, Day, Year)

7-14-1951

9. Birthplace (State or Foreign Country)

Keyser, WV

Usual Residence of Decedent

10a. State

WV

10b. County

Grant

10c. City, Town or Location

Mt. Storm

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

HC 76, Box 314

10f. Zip Code

26739

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

Petersburg Elementary School

17. Father's Name (First, Middle, Last)

Harry Wilson Bobo

18. Mother's Name (First, Middle, Maiden Surname)

Jessie Hilda Hanlin Bobo

19a. Informant's Name/Relationship (Type, Print)

Jessie Bobo - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

HC 76, Box 314 - Mt. Storm, WV 26739

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Locust Grove Cemetery

Date

1-26-2008

20c. Location - City or Town, State

Mt. Storm, WV

21. Signature of Funeral Service Licensee

Melody Baker

22. Name and Address of Facility

Basagic Funeral Home POB 400 Petersburg, WV 26847

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Non-Small Cell Carcinoma of the Lung

Approximate Interval Between Onset and Death

May 2007

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death Check only one

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 23371

29d. Date signed (Month, Day, Year)

January 24, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Qamar Zaman MD 904 Seton Drive Cumberland Maryland 21502

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02780

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Robert L. Balsamo

2. Date of Death  
Month Day Year

January 28 2008

3. Time of Death

0909 AM

4a. Facility Name (If not institution, give street and number)

Saint Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

None

5. Social Security Number

217-24-8102

6. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
Yrs.

77

8. Date of Birth (Month, Day, Year)

Jul 11, 1930

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Gwynn Oak

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1176 Newfield Rd.

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Railroad

17. Father's Name (First, Middle, Last)

Salvatore Balsamo

18. Mother's Name (First, Middle, Maiden Surname)

Diana Franzoni

19a. Informant's Name/Relationship (Type, Print)

Peggy Balsamo Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1176 Newfield Rd. Gwynn Oak, MD 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

Jan 31, 2008

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Melody B. Burt

22. Name and Address of Facility

Slack Funeral Home, P.A.  
3871 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction

Approximate Interval Between Onset and Death

Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

falsano

29c. License number

D47353

29d. Date signed (Month, Day, Year)

January 28, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jon Falsano, MD St. Agnes Hospital 900 Caton Avenue Baltimore, Maryland 21229

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

falsano

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 02781

1- For State Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) Richard Gordon Brown Jr. 2. Date of Death Month Day Year February 1 2008 3. Time of Death 6:35a M

4a. Facility Name (If not institution, give street and number) Transitions Health Care 4b. City, Town, or Location of Death Sykesville 4c. County of Death Carroll

Funeral Director

5. Social Security Number 496-26-1519 6. Sex 1 ☒ M 2 ☐ F 7. Age (In yrs. last birthday) 80 Yrs. 8. Date of Birth (Month, Day, Year) Dec 1 1927 9. Birthplace (State or Foreign Country) Kansas

Usual Residence of Decedent 10a. State MD 10b. County Howard 10c. City, Town or Location Highland 10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number 6725 Montell Court 10f. Zip Code 20777 10g. Citizen of What Country? USA

11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) +1 College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) analyst 16b. Kind of Business/Industry U.S. Government

17. Father's Name (First, Middle, Last) Richard Gordon Brown Sr. 18. Mother's Name (First, Middle, Maiden Surname) Berenice Lillian Slayton

19a. Informant's Name/Relationship (Type, Print) Douglas J. Brown (son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9744 Basket Ring, Columbia, MD 21045

20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation 20c. Location - City or Town, State Sykesville, MD

21. Signature of Funeral Service Licensee [Signature] 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. anemia 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

Chronic renal insufficiency 24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No Cerebrovascular accident

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier [Signature] 29c. License number D 0055926 29d. Date signed (Month, Day, Year) 2/1/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William J. Hammerash Jr 708C Lisbon Center Dr Woodbine MD 21797

31. Date filed (Month, Day, Year) FEB 04 2008 32. Registrar's Signature [Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State and Local Health Officers, 10a-c, 10e-f, 16a, per FH, 876, 2/4/08, JT

Certificate of Death

Reg. No. 2008 02782

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>William R. Berry</b>  |  | 2. Date of Death<br>Month <b>January</b> Day <b>25</b> Year <b>2008</b>   |  | 3. Time of Death<br><b>5:53 a M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Southern Maryland Hospital Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Clinton</b>  |  | 4c. County of Death<br><b>Prince George's</b>  |  |
| 5. Social Security Number<br><b>727-01-7899</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>12/08/1920</b> | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Prince George's</b>                                      | 10c. City, Town or Location<br><b>Forestville</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>3821 Halley Terrace S.E.</b>  |  | 10f. Zip Code<br><b>20747</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Maintenance Worker</b>   |  |
| 16b. Kind of Business/Industry<br><b>Building Maintenance</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>John Berry</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>(unknown) Dawkins</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Modestine Byrd / Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>108 Brookside Road, Spartanburg, SC 29301</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>M.I. Cooper Veterans Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Anderson, SC</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Dorota W. Marshall</b>   |  | 22. Name and Address of Facility<br><b>Charles L. Stevens Funeral Home Inc.<br/>1501 East Fort Avenue, Baltimore, MD 21230</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>ACUTE MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><b>CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  |   |  |  | Approximate Interval Between Onset and Death |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input checked="" type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input checked="" type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSION</b>  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |  | 29c. License number<br><b>D 40324</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>January 25, 2008</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>TERRY JODRIE, MD 7503 SURREATS ROAD, CLINTON, MARYLAND 20735</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 11 per adm of estate 6886, 12-8-08 vt

State of Maryland Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02783

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |   |  |                                |  |  |
|---|--|---|---|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Alma Regina Becker</b>   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>January 27 08</b>   |                                | 3. Time of Death<br><b>0220 M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Lorien @ Riverside</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>Belcamp</b>   |                                | 4c. County of Death<br><b>Harford</b>  |  |
| 5. Social Security Number<br><b>495-32-9687</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>100</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>June 22, 1907</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Illinois</b>   |  |   |   |  |                                |  |  |
| Usual Residence of Decedent   |  |   |   |  |                                |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Harford</b>   |   | 10c. City, Town or Location<br><b>Belcamp</b>  |                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>1123 Belcamp Garth</b>   |  |   |   | 10f. Zip Code<br><b>21017</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>candy packer</b>   |                                | 16b. Kind of Business/Industry<br><b>confectionaries</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Christian Becker</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaretha Carolina Reichert</b>   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Lorien at Riverside</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1123 Belcamp Garth Belcamp, MD 21017</b>   |                                |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |   | Date   |                                | 20c. Location - City or Town, State  |  |
| 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>  |  |   |   | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street<br/>Baltimore, MD 21201</b>   |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death  |  |   |   |  |                                |  |  |
| Immediate Cause (Final disease or condition resulting in death)   |  |   |   |  |                                |  |  |
| a. <b>myocardial infarction</b> Due to (or as a consequence of):  |  |   |   |  |                                |  |  |
| b. <b>congestive heart failure</b> Due to (or as a consequence of): <b>year</b>   |  |   |   |  |                                |  |  |
| c. <b>coronary artery disease</b> Due to (or as a consequence of): <b>year</b>  |  |   |   |  |                                |  |  |
| d.  |  |   |   |  |                                |  |  |
| IF FEMALE:  |  |   |   |  |                                |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)                                       |   | 23d. Date of delivery<br>Month Day Year  |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Angina, hypothyroidism</b>   |  |   |   |  |                                | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |                                |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                                |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   |  | 28d. Describe how injury occurred   |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |                                |  |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>   |  |   |   | 29c. License number<br><b>027975</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>1/28/08</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID McCLURE 615 MacPhail rd Bel Air MD 21014</b>   |  |   |   |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |                                |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ALMA R. BECKER  
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02784

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marie A. P. Childs

2. Date of Death

January 31, 2008

3. Time of Death

8:23 PM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

223-34-5354

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months

Days

Hours

Min.

8. Date of Birth

11 18 29

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1672 Darley Ave

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dietary

16b. Kind of Business/Industry

K-Mart

17. Father's Name (First, Middle, Last)

Forrest Harris

18. Mother's Name (First, Middle, Maiden Surname)

Signora Garrett

19a. Informant's Name/Relationship (Type, Print)

Nikki Fowlkes-Grand Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1672 Darley Ave Baltimore, MD 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

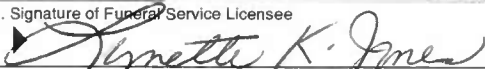
King Memorial Pk. 1/7/08

Date

20c. Location - City or Town, State

Randallstown, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

March F/H East

1101 E. North Ave Baltimore, MD 21202

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myelodysplastic Syndrome

Approximate Interval Between Onset and Death

5 years

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. End Stage Renal Disease

10 years

c. Chronic Obstructive Pulmonary Disease

15 years

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

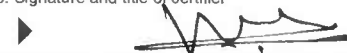
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

AT2438946

29d. Date signed (Month, Day, Year)

January 31, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vinay Jagadeesha, M.D., Union Memorial Hospital, MD

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar amend #30 Per DVR G876 2/04/08, JH  
 State of Maryland / Department of Health and Mental Hygiene  
 Certificate of Death  
 Reg. No. 2008 02785

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, 21230

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><i>John Howard Condit</i>   |  | 2. Date of Death<br>Month <i>01</i> Day <i>26</i> Year <i>08</i>  |  | 3. Time of Death<br><i>4:30 PM</i>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><i>Holy Cross Hospital</i>  |  | 4b. City, Town, or Location of Death<br><i>Silver Spring</i>  |  | 4c. County of Death<br><i>Montgomery</i>   |  |
| 5. Social Security Number<br><i>231-03-6470</i>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><i>87</i> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><i>09-19-20</i>  |  | 9. Birthplace (State or Foreign Country)<br><i>Virginia</i>   |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |
| 10a. State<br><i>Maryland</i>   |  | 10b. County<br><i>Montgomery</i>  |  | 10c. City, Town or Location<br><i>Silver Spring</i>  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><i>2501 Musgrove Rd</i>   |  | 10f. Zip Code<br><i>20904</i>  |  |
| 10g. Citizen of What Country?<br><i>USA</i>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <i>5+</i>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Dentist</i>   |  | 16b. Kind of Business/Industry<br><i>Self-Employed</i>   |  |
| 17. Father's Name (First, Middle, Last)<br><i>Arthur Condit</i>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Mildred Clements</i>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>John H. Condit Jr. - Son</i>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>P.O. BOX 530, Burtonsville, MD 20866</i> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Sherman Memorial Park</i>  |  | 20c. Location - City or Town, State<br><i>SALEM VIRGINIA</i>   |  |
| 21. Signature of Funeral Service Licensee<br><i>John N. Brown</i>   |  | 22. Name and Address of Facility<br><i>Hamber - Curtis Funeral Home<br/>1002 Moorman Rd, Roanoke, VA 24016</i>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. Respiratory Failure</i><br><i>b. Pneumonia</i><br><i>c. Sepsis</i><br><i>d. Parkinson Disease</i>                                   |  |   |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  |   |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)   |  |   |  |  |  |
| 23d. Date of delivery<br>Month Day Year   |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><i>M</i>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>W. M. Shee</i>  |  | 29c. License number<br><i>762520</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>01-27-08</i>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Maria Kayaga D'Arbela P.O. Box 9091 Silver Spring, MD. 20916</i>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>FEB 04 2008</i>   |  |   |  |  |  |
| 32. Registrar's Signature<br><i>John N. Brown</i>   |  |   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
 amend #29d Per Phy G876 2/04/08 Jh  
 Certificate of Death

Reg. No. 2008 02786

1. Decedent's Name (First, Middle, Last) **IRA CRUMBACKER**

2. Date of Death  
 Month **JAN** Day **31** Year **2008**

3. Time of Death **8:10 AM**

4a. Facility Name (If not institution, give street and number) **NORTHWEST HOSPITAL**

4b. City, Town, or Location of Death **RANDALLSTOWN**

4c. County of Death **BALTIMORE**

5. Social Security Number **213-10-5722**

6. Sex ☒ M ☐ F

7. Age (In yrs. last birthday) **87** Yrs.

8. Date of Birth (Month, Day, Year) **Nov. 7, 1920**

9. Birthplace (State or Foreign Country) **Maryland**

10a. State **MD**

10b. County **Baltimore**

10c. City, Town or Location **Reisterstown**

10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **2 Ivy Bridge Court**

10f. Zip Code **21136**

10g. Citizen of What Country? **USA**

11. Marital Status  
☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
☒ Yes ☐ No  
 If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.  
 Specify: **White**

15. Decedent's Education (Specify only highest grade completed)  
 Elementary/Secondary (0-12) **4** College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
**Civil Service**

16b. Kind of Business/Industry  
**US Government**

17. Father's Name (First, Middle, Last) **Raymond Crumbacker**

18. Mother's Name (First, Middle, Maiden Surname) **Marguerite Ridgley**

19a. Informant's Name/Relationship (Type, Print) **Helen Crumbacker Wife**

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
**2 Ivy Bridge Court, Reisterstown, MD 21136**

20a. Method of Disposition  
☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) **Pipe Creek Cemetery**

20c. Location - City or Town, State **New Windsor, MD**

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
**Eline Funeral Home 11824 Reisterstown Road Reisterstown, MD 21136**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
 Immediate Cause (Final disease or condition resulting in death)  
**CARDIOMYOPATHY**  
 Due to (or as a consequence of):  
**CHRONIC KIDNEY DISEASE**  
 Due to (or as a consequence of):  
 Due to (or as a consequence of):  
 Due to (or as a consequence of):

23b. Was decedent pregnant in the past 12 months?  
☐ Yes ☒ No ☐ Unknown

23c. If yes, outcome of pregnancy  
☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (Specify)  
☐ Unknown

23d. Date of delivery  
 Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?  
☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?  
☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
☐ Yes ☐ No

25. Was case referred to medical examiner?  
☐ Yes ☒ No

26. Place of Death (Check only one)  
 Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DCA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death  
☒ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury **M**

28c. Injury at Work? ☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number **D0066357**

29d. Date signed (Month, Day, Year) **Jan 31 2008**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
**VENKATA REDDWAR NORTHWEST HOSPITAL**

31. Date filed (Month, Day, Year) **FEB 04 2008**

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02787

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wilhelmina R. Duvall

2. Date of Death  
Month Day Year  
January 29, 20083. Time of Death  
7:30 P<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Manorcare of Woodbridge Valley

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

215-18-7748

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

July 4, 1917

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number

6012 Old Frederick Rd.

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Educator

16b. Kind of Business/Industry

Balto. School System

17. Father's Name (First, Middle, Last)

Willie Ray

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Patterson Ray

19a. Informant's Name/Relationship (Type, Print) (Husband)

Mr. John Duvall

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6012 Old Frederick Rd. Balto. Md. 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Mem Park

Date

2/4/2008

20c. Location - City or Town, State

Balto. Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home P.A.  
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ALZHEIMER'S DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC KIDNEY DISEASE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

UMA M.D.

29c. License number

D0059107

29d. Date signed (Month, Day, Year)

02-01-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KALU UMA, 210 BUSINESS CENTER DRIVE, REISTERSTOWN MD 21136

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02788

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Michael George Dana, PHD

2. Date of Death

Month Day Year  
Jan 28, 2008

3. Time of Death

2:55 PM

4a. Facility Name (If not institution, give street and number)

2517 Melba Rd.

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

5. Social Security Number

556-44-9705

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Sep 2, 1935

9. Birthplace (State or Foreign Country)

CA

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2517 Melba Rd.

10f. Zip Code

21042

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Criminologist

16b. Kind of Business/Industry

US Government

17. Father's Name (First, Middle, Last)

Mitchell Dana

18. Mother's Name (First, Middle, Maiden Surname)

Angelina Saladino

19a. Informant's Name/Relationship (Type, Print)

Ellen Dana Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2517 Melba Rd. Ellicott City, MD 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

New Cathedral Cemetery

Date

Jan 31, 2008

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Melody B. Bright Moore

22. Name and Address of Facility

Slack Funeral Home, P.A.  
3871 Old Columbia Pike Ellicott City, MD 2104323a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. METASTATIC BREAST CANCER

Approximate  
Interval Between  
Onset and Death

5 YEARS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

EW Cole MD

29c. License number

D16354

29d. Date signed (Month, Day, Year)

1/30/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EW COLE STAGNES 900 CATON AVE BALTIMORE MD 21229

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02789

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James David Dustin

2. Date of Death

January 30 2008

3. Time of Death

8:45p M

4a. Facility Name (If not institution, give street and number)

Carroll Hospice Dove House

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

219-56-2672

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan 25 1939

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

525 Klee Mill Road

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

farm laborer

16b. Kind of Business/Industry

agriculture

17. Father's Name (First, Middle, Last)

William J. Dustin Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Barnes

19a. Informant's Name/Relationship (Type, Print)

Robert Dustin (brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

453 Klee Mill Rd., Sykesville, MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Emmanuel UMC Cemetery

Date

2-2-08

20c. Location - City or Town, State

Scaggsville, MD

21. Signature of Funeral Service Licensee

► Paig Haiger Herbert

22. Name and Address of Facility

Haight Funeral Home & Chapel  
P.O. Box 195 Sykesville, MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Congestive Heart Failure

Approximate Interval Between Onset and Death

Days

b. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► [Signature]

29c. License number

00059943

29d. Date signed (Month, Day, Year)

January 31, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John C. Azuma 295 Spenser Ave. Suite 307 Westminster MD 21157

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02790

1. For **Recommend #21&22** Per Ana BD G876 2/04/08 JH  
Registrar

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |   |  |   |   |  |
|--|--|---|---|--|--|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM DYER</b>                        |   |   | 2. Date of Death<br>Month <b>1</b> Day <b>9</b> Year <b>08</b>   |  |   | 3. Time of Death<br><b>10:55 PM</b>                    |   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>FRIENDS HOUSE</b> |   |   | 4b. City, Town, or Location of Death<br><b>SANDY SPRING, MD</b>  |  |   | 4c. County of Death<br><b>MONTGOMERY</b>               |   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>153013633</b>  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs. |   | 8. Date of Birth (Month, Day, Year)<br><b>12/27/17</b> |   | 9. Birthplace (State or Foreign Country)<br><b>NEW JERSEY</b>           |  |
|  | Usual Residence of Decedent  |   |   |  |  |   |  |   |   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>MONTGOMERY</b>  |   | 10c. City, Town or Location<br><b>SANDY SPRING</b>   |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>17401 NORWOOD ROAD</b>  |  |   |   | 10f. Zip Code<br><b>20860</b>  |  |   | 10g. Citizen of What Country?<br><b>U.S.</b>           |   |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1941-5</b> |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 TH</b> College (1-4 or 5+)  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MECHANIC</b> |  |   |  | 16b. Kind of Business/Industry  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>ORRIN DYER</b>   |  |   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FRANCES DONAGHAY</b>  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JOAN LIVERSIDGE / Daugh.</b>  |  |   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21044 6283 CENTRE STONE RING, COLUMBIA, MD</b>   |  |   |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MARYLAND ANATOMY BD</b>                         |  | Date  |  | 20c. Location - City or Town, State<br><b>BALTIMORE, MD</b>                             |   |  |
| 21. Signature of Funeral Service Licensee<br>▶ <b>Ronald S. Wade, Director</b> Per <b>DVR.</b>   |  |   |   |  |  | 22. Name and Address of Facility<br><b>State Anatomy Bd, 655 W. Balto. St. Baltimore, MD, 21210</b>   |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>HIP FRACTURE, WITH COMPLICATIONS</b>  |  |   |   |  |  |   |  |   |   |  |
| Approximate Interval Between Onset and Death<br><b>2 DAYS</b>  |  |   |   |  |  |   |  |   |   |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><b>on 1/29/08 MD DME</b>   |  |   |   |  |  |   |  |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |   |   |  |  |   |  |   |   |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)  |  |   |   |  |  |   |  |   |   |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |   |  |  |   |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CONGESTIVE HEART FAILURE</b>  |  |   |   |  |  |   |  |   |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |   |  |  |   |  |   |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |  |  |   |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |  |  |   |  |   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |  |  |   |  |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |   |  |  |   |  |   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br><b>1/7/08</b>   |   | 28b. Time of Injury<br><b>6:55 AM</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>FELL</b>  |   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>AT NURSING HOME</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>SANDY SPRING, MD</b> |   |  |  |   |  |   |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |   |  |   |   |  |
| 29b. Signature and title of certifier<br>▶ <b>Robert Fields MD</b>   |  |   |   |  |  | 29c. License number<br><b>D34740</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>1/23/08</b>                                   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ROBERT P. FIELDS, MD 18109 PRINCE PHILIP DR, OLNEY, MD 20832</b>  |  |   |   |  |  |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |   |  |   |   |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02791

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Arthur Drumwright

2. Date of Death

Month Day Year  
01 26 2008

3. Time of Death

3:27 P M

4a. Facility Name (If not institution, give street and number)

4022 EDMONDSON AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

215-24-8370

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 5, 1928

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4022 Edmondson Avenue

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: African American

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

laborer

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Ross Drumwright

18. Mother's Name (First, Middle, Maiden Surname)

Ella White

19a. Informant's Name/Relationship (Type, Print)

Dorethea Lee / Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

610 Wildwood Parkway; Baltimore, MD 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Garrison Forest Vet. Cem.

Date

01/31/2008

20c. Location - City or Town, State

Owings Mills, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Wylie Funeral Home, P.A.

638 North Gilmore Street; Baltimore, MD 21217

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Cerebrovascular Accident  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PROSTATE CANCER

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DS7722

29d. Date signed (Month, Day, Year)

JANUARY 31 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEONARD RICHARDSON M.D. 1838 GREENE TREE ROAD # 300 Pikesville, MD 21208

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02792

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Mary Eberle

2. Date of Death

January 30, 2008

3. Time of Death

6:15AM M

4a. Facility Name (If not institution, give street and number)

Calvert Manor Health Care Center

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

5. Social Security Number

213-74-4136

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

101

8. Date of Birth (Month, Day, Year)

Oct. 17, 1906

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

27 W. Chestnut Hill Lane

10f. Zip Code

21136

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Miller

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Slitzer

19a. Informant's Name/Relationship (Type, Print)

Lynn M. Hechmer Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11221 Woodrush Court, San Diego, CA 92128

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery 2/2/08

Date

20c. Location - City or Town, State

Pikesville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Eline Funeral Home

11824 Reisterstown Road

Reisterstown, MD 21136

a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death  
1 week.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia of Alzheimer's Type

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

Neil E. Lattin, M.D.

29c. License number

D0058354

29d. Date signed (Month, Day, Year)

01/30/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neil E. Lattin, M.D. 101 Colonial Way, Rising Sun, MD 21141

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02793

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

David E. Edwards

2. Date of Death

Month 01/ Day 27/ Year 2008

3. Time of Death

7:00 A<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

245-58-4355

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

66

8. Date of Birth (Month, Day, Year)

09/10/1941

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3222 10th Place SE

10f. Zip Code

20032

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

X-Ray Technician

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Lannie Taylor

18. Mother's Name (First, Middle, Maiden Surname)

Jewel Edwards

19a. Informant's Name/Relationship (Type, Print)

Stephanie Kerney/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8512 Snowden Loop Laurel, MD 20708

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Taylor Cemetery

Date

02/01/08

20c. Location - City or Town, State

Snow Hill, NC

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ronald Taylor II Funeral Hm.

108 West North Ave. Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Prostate Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)  
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D56691

29d. Date signed (Month, Day, Year)

01/27/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ghousia Sultana 1500 Forest Glen Road, Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

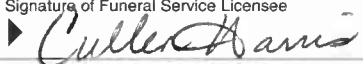
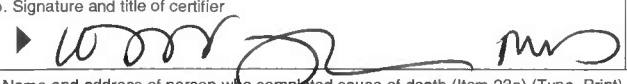
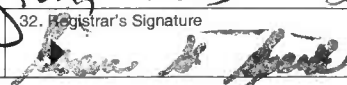
State of Maryland / Department of Health and Mental Hygiene

2008 02794

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |   |   |  |  |   |  |
|---|--|--|---|--|--|--|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Lillie Beatrice Foster</b>  |  |   |  | 2. Date of Death<br>Month <b>January</b> Day <b>26</b> , Year <b>2008</b>  |  |   |   | 3. Time of Death<br><b>5:00 PM</b>   |  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Hopkins Bayview</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  |   |   | 4c. County of Death<br><b>N/A</b>  |  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-36-8405</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 25, 1943</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |   |  |
|   | Usual Residence of Decedent  |  |   |  |  |  |   |   |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |  |
|   | 10e. Street and Number<br><b>4406 Bowleys Lane Apt. 1B</b>   |  |   |  | 10f. Zip Code<br><b>21206</b>  |  |   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>12th Grade</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Registered Nurse</b>   |  |   |   | 16b. Kind of Business/Industry<br><b>Private Duty</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Bess Wilkerson</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Lou Davis</b>   |  |   |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Earl Wilkerson/ Son</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6303 Monika Place #1309 Baltimore, MD 21207</b>  |  |   |   |  |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetery</b>   |  |   |   | Date<br><b>2/1/08</b>  |  | 20c. Location - City or Town, State<br><b>Lansdowne, MD</b> |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Chatman-Harris Funeral Home</b><br><b>4210 Belair Rd. Baltimore, MD 21206</b>   |  |   |   |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cardiovascular disease</b><br>Due to (or as a consequence of):<br>b. <b>Pulmonary hypertension</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>Several years</b><br><b>several years</b> |  |   |  |  |  |   |   |  |  |   |  |
|   | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year  |  |   |  |  |  |   |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |  |  |  |   |   |  |  |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |   |  |  |  |   |   |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |  |  |   |   |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |  |  |  |   |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |  |  |   |   |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |   |  |  |  |   |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |  |   |  |  |  |   |   |  |  |   |  |
| 28a. Date of Injury (Month, Day Year)   |  |  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how injury occurred                     |  |  |   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                     |  |  |   |   |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |  |  |   |   |  |  |   |  |
| 29b. Signature and title of certifier<br>  |  |  |   | 29c. License number<br><b>D46581</b>   |  |  |   | 29d. Date signed (Month, Day, Year)<br><b>1/31/08</b> |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Verlyn Warrington, MD</b> <b>295. Paca St. Balt., MD 21201</b>   |  |  |   |  |  |  |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b>   |  |  |   | 32. Registrar's Signature<br> |  |  |   |   |  |  |   |  |

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2008 02796

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wanda E. Farmer

2. Date of Death  
Month Day Year  
January 24, 2008  
3. Time of Death  
11:50AMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

579-88-0630

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

48

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 30, 1959

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2015 Randolph Road #202

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Public Relations

16b. Kind of Business/Industry

Pvt.

17. Father's Name (First, Middle, Last)

Warren Hawkins

18. Mother's Name (First, Middle, Maiden Surname)

Mary Garrison

19a. Informant's Name/Relationship (Type, Print)

Calvin Farmer/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

560 College Parkway  
Rockville, MD 20850

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Riverdale Crematory 1/30/08 Riverdale, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Austin Royster Funeral Home

3821 14th Street, NW, Washington, DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. DEATH BY NEUROLOGIC CAUSE

Due to (or as a consequence of):

b. STROKE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

00052774

29d. Date signed (Month, Day, Year)

1/28/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEO C. ROTELLO MD

SUBURBAN HOSPITAL, BETHESDA MD

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

FARMER, WANDA 1/24/08 1150AM

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend #20b per FH G876 2/13/08 Jh

Certificate of Death

Reg. No. 2008 02797

1- For State Registrar

Physician /Medical Examiner

Funeral Director

|  |  |   |   |  |
|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Lois B. Gross</b>   |  | 2. Date of Death<br>Month: <b>JANUARY</b> Day: <b>29</b> Year: <b>2008</b>  |   | 3. Time of Death<br><b>4:40 AM</b>   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital of Baltimore</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |   | 4c. County of Death<br><b>N/A</b>  |
| 5. Social Security Number<br><b>215-24-0003</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>81</b>   | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 30, 1926</b> | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>   |
| 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>N/A</b>   | 10c. City, Town or Location<br><b>Baltimore</b>             |  |
| 10e. Street and Number<br><b>3207 Clifton Ave.</b>   |  | 10f. Zip Code<br><b>21216</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Typist</b>  |   | 16b. Kind of Business/Industry<br><b>U.S. Dept. of Transportation</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>John Gilliam</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie Mayfield</b>   |   |  |
| 19a. Informant's Name/Relationship (Type, Print) (Sister)<br><b>Mrs. Mary Flack</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3207 Clifton Ave. Balto. Md. 21216</b>  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Trinity Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>Balto. Md.</b>   |
| 21. Signature of Funeral Service Licensee<br><b>Joseph L. Russ</b>   |  | 22. Name and Address of Facility<br><b>Joseph L. Russ Funeral Home P.A.<br/>2222 W. North Ave. Balto. Md. 21216</b>   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Sepsis</b>  |  |   |   | Approximate Interval Between Onset and Death<br><b>6 days</b>  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.  |  |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input checked="" type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)         |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br><b>M</b>                             | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and Title of certifier<br><b>Nicole L. Stroud, MD</b>  |   | 29c. License number<br><b>RES-000</b>  |
| 29d. Date signed (Month, Day, Year)<br><b>JANUARY 29, 2008</b>   |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Nicole L Stroud, MD Sinai Hospital of Baltimore</b>   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

GORDON K. GRIMES SR.

2. Date of Death

FEBRUARY 2 2008

3. Time of Death

9:55 AM

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

219-20-7636

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11/10/1927

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1443 Richardson Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: Coast Guard

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Longshoreman

16b. Kind of Business/Industry

Shipping

17. Father's Name (First, Middle, Last)

Vernon Grimes Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Daisy Brown

19a. Informant's Name/Relationship (Type, Print)

Gordon Grimes Jr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1443 Richardson Street, Baltimore, MD 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial Park

Date

2/6/2008

20c. Location - City or Town, State

Glen Haven MD

21. Signature of Funeral Service Licensee

Victor P. Doda

22. Name and Address of Facility

Charles L. Stevens Funeral Home Inc.  
1501 East Fort Avenue, Baltimore, MD 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. CAD

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D23530

29d. Date signed (Month, Day, Year)

2-2-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASHOK K CHATTERJEE 3001 S. Hanover St. MD 21225

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

## Certificate of Death

Reg. No.

2008 02799

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marie Giardina

2. Date of Death

Month Day Year  
1 13 08

3. Time of Death

5:35 PM

4a. Facility Name (If not institution, give street and number)

Charlestown Health Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

212-50-3606

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov 9, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

707 Maiden Choice Lane #3202

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

housewife

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Joseph Luczkowski

18. Mother's Name (First, Middle, Maiden Surname)

Mary Anna Koslowski

19a. Informant's Name/Relationship (Type, Print)

Joseph A. Giardina/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6810 Dina Leight Court Springfield, VA 22153

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Lung cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Deneen Bowlin, MD

29c. License number

D44372

29d. Date signed (Month, Day, Year)

1/15/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deneen Bowlin, MD 711 Maiden Choice Lane Catonsville MD 21228

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

James H. Smith

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For  
amend #31 Per  
State Registrar

DVR G876 2/04/08 JH

Certificate of Death

Reg. No. 2008 02800

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ALLEN C GREENBERG</b>  |  | 2. Date of Death<br>Month <b>JANUARY</b> Day <b>26</b> Year <b>2008</b>   |  | 3. Time of Death<br><b>3:10P M</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>DOVE HOUSE</b>   |  | 4b. City, Town, or Location of Death<br><b>WESTMINSTER</b>  |  | 4c. County of Death<br><b>CARROLL</b>  |  |
| 5. Social Security Number<br><b>219-22-3625</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>12/26/1925</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>CARROLL</b>   |  | 10c. City, Town or Location<br><b>WESTMINSTER</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>750 CROWS COURT, APT. #3-B</b>   |  | 10f. Zip Code<br><b>21158</b>  |  |
| 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII</b><br>If Yes, Give Year or Dates: <b>KOREA</b>   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>FOREIGN LANGUAGE</b>  |  | 16b. Kind of Business/Industry<br><b>US NAVY</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>GEORGE GREENBERG</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ROSE FISHER</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>VIVIAN SHAPIRO / SISTER</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>45 WASHINGTON ROAD, WESTMINSTER, MD 21157</b>  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD VETERAN CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>OWINGS MILLS, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael Sugar</i>   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on this line.<br><b>Metastatic bladder cancer</b>  |  |
| 23b. Immediate Cause (Final disease or condition resulting in death)  |  | 23c. Due to (or as a consequence of):   |  | Approximate Interval Between Onset and Death<br><b>5y 9mos</b>   |  |
| 23d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Last of injury that initiated events resulting in death) Last  |  | 23e. Due to (or as a consequence of):   |  |  |  |
| 23f. Due to (or as a consequence of):   |  | 23g. Due to (or as a consequence of):   |  |  |  |
| 23h. Due to (or as a consequence of):   |  | 23i. Due to (or as a consequence of):   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24c. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>Paulo Kruter MD</i>  |  |
| 29c. License number<br><b>D35398</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>01-28-08</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Paulo Kruter MD 555 S. Cntr. Street Westminster, MD 21157</b>   |  |
| 31. Date filed (Month, Day, Year)<br><b>1-28-08</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  | 33. Date of filing<br><b>FEB 04 2008</b>   |  |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02801

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |
|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Edna Harris</b>  |  | 2. Date of Death<br>Month Day Year<br><b>January 22, 2008</b>   |  | 3. Time of Death<br><b>3:00A<sup>M</sup></b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Genesis Health Care</b>  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-22-4951</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 3, 1928</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Baltimore</b>  |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Randallstown</b>   |
|  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |
|  | 10e. Street and Number<br><b>3710 Sonora Raod</b>   |  | 10f. Zip Code<br><b>21133</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:        |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Pvt.</b>  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Carroll Chaney</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edna Peregoy</b>  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lawrence T. Harris/Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7859 Lockwood Road<br/>Baltimore, MD 21222</b>  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Howard University</b>  |  | 20c. Location - City or Town, State<br><b>Washington, DC</b>   |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Austin Royster FUNeral Home<br/>3821 14th Street, NW, Washington, DC 20011</b>   |  |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on line.  |  |   |  | Approximate Interval Between Onset and Death   |
|  | Immediate Cause (Final disease or condition resulting in death)<br>a. <b>METASTATIC COLON CANCER</b><br>Due to (or as a consequence of):  |  |   |  |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. <b>CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):  |  |   |  |  |
|  | c. <b>HYPERTENSION</b><br>Due to (or as a consequence of):  |  |   |  |  |
|  | d.  |  |   |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death<br>9 <input type="checkbox"/> Unknown   |  | 23d. Date of delivery<br>Month Day Year  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner                   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |
|  | 29b. Signature and title of certifier<br><b>Savinder K Tuli MD</b>  |  | 29c. License number<br><b>D27188</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>1/23/08</b>  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Savinder K Tuli, 2 Market-Place Dandalk MD 21222</b>   |  |   |  |  |
|  | 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b>   |  | 32. Registrar's Signature<br>   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02802

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Weldon P. Hale

2. Date of Death

February 1<sup>st</sup> 2008

3. Time of Death

08:40 P M

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

217-24-2704

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

8. Date of Birth

Sept. 23, 1927

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Owings Mills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11940 Park Heights Avenue

10f. Zip Code

21117

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates: 1944-48

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Police Officer

16b. Kind of Business/Industry

Baltimore County

17. Father's Name (First, Middle, Last)

John E. Hale

18. Mother's Name (First, Middle, Maiden Surname)

Lillie M. Ashe

19a. Informant's Name/Relationship (Type, Print)

Shirley J. Kienle - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11940 Park Heights Avenue, Owings Mills, MD 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Grace Cemetery

Date

2-6-08

20c. Location - City or Town, State

Reisterstown, MD

21. Signature of Funeral Service Licensee

ELINE FUNERAL HOME

22. Name and Address of Facility

11824 Reisterstown Road

Reisterstown, MD 21136

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cerebrovascular Accident

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation, history of lung cancer with resection in past.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kapil Gangwal MD.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

February 1<sup>st</sup> 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kapil-Gangwal M.D. Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Physician /Medical Examiner

15+

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
amend #5 Per Fil 6876 2/11/08 JH  
Certificate of Death1- For  
State  
Registrar

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WALTER HARRIS JR.

2. Date of Death

JAN 31 2008

3. Time of Death

11:04 AM

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

215-12-9367

6. Sex

M

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 29, 1922

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State  
Maryland10b. County  
N/A10c. City, Town or Location  
Baltimore10d. Inside City Limits  
☒ Yes ☐ No

10e. Street and Number

1108 Darley Avenue

10f. Zip Code

21218

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Walter Harris, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Jannie Warren

19a. Informant's Name/Relationship (Type, Print)

Doris R. Harris - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1108 Darley Ave. Baltimore, Maryland 21218

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Cemetery

Date

Feb 6, 2008

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Calvin L. Williams

22. Name and Address of Facility

CALVIN L. WILLIAMS F.S. RA.  
270 Fredrickson Pass Balto, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPTIC SHOCK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PNEUMONIA

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)  
☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy performed?  
☐ Yes ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
☐ Yes ☒ No25. Was case referred to medical examiner?  
☐ Yes ☒ No26. Place of Death (Check only one)  
Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA  
Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W. H. Harris

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

Jan 31, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WYEL HAKIM 5601 LEXA RAVEN BLVD. BALTIMORE, MD, 21239

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitHARRIS, WALTER  
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02804

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Beatrice V. Hall

2. Date of Death

Month 1 Day 18 Year 2008

3. Time of Death

5:15 a M

4a. Facility Name (If not institution, give street and number)

Manor Care Nursing Home

4b. City, Town, or Location of Death

Largo

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

578-36-4392

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

8. Date of Birth (Month, Day, Year)

9-19-1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

P.G.

10c. City, Town or Location

District Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2001 County Rd.

10f. Zip Code

20747

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housekeeper

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Tilghman

19a. Informant's Name/Relationship (Type, Print)

Delorise V. Brooks/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2001 County Rd. District Heights, MD 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cem.

Date

01/26/08

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensed

Ronald Taylor II

22. Name and Address of Facility

Ronald Taylor II Funeral Hm.  
108 West North Ave. Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

b. HEMORRHAGIC STROKE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

FAILURE TO THRIVE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

SOBHAN MATHEW

29c. License number

D47604

29d. Date signed (Month, Day, Year)

01/24/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SOBHAN MATHEW, 3048 MITCHELLVILLE ROAD, BOWIE, MD 20716

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02805

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bernell Harris

2. Date of Death  
Month Day Year  
1-26-20083. Time of Death  
9:55 MFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

314-26-9481

6. Sex  
☒ M ☐ F

7. Age (In yrs. last birthday)

74

8. Date of Birth (Month, Day, Year)

April 17, 1933 Illinois

Usual Residence of Decedent

10a. State

Md

10b. County

Montgomery Co.

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2001 Spencer Rd.

10f. Zip Code

20910

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No 5-29-  
If Yes, Give  
Year or Dates: 195713. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Judson Harris

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Mable Harris/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2001 Spencer Rd. Silver Spring, Md 20910

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Md. Veterans Ceme. 2-06-2008 Cheltenham, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

R. Taylor

22. Name and Address of Facility

Ronald Taylor II Funeral Hm

108 W. North Ave. Baltimore, Md. 21201

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause in each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Renal Failure

Due to (or as a consequence of):

Polycystic Kidney Disease

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dr. Tolia, Ashish DO

29c. License number

H0064588

29d. Date signed (Month, Day, Year)

1-27-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Tolia, Ashish Holy Cross Hospital 1500 Forest Silver Spring, Md 20910

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #8, per FH, 876, 2/25/08 TT Certificate of Death

Reg. No. 2008 02806

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CONNIE IZZEPPI

2. Date of Death

January 30, 2008

3. Time of Death

5:20 P M

4a. Facility Name (If not institution, give street and number)

Heritage Nursing Home

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

154-66-8975

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

12/8/1920

9. Birthplace (State or Foreign Country)

Guatemala

Usual Residence of Decedent

10a. State

NJ

10b. County

10c. City, Town or Location

Perth Amboy

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

415 Fayette Street

10f. Zip Code

08861

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☒ Yes ☐ No

Specify: Guatemalan

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NURSE

16b. Kind of Business/Industry

Healthcare

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type. Print)

Luis Alvarado - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6606 Buskin Ln., Glen Burnie, Md 21060

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory

Date

2-1-08

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bradley-Ashton Funeral Home, P.A., 2134 W. How Springs Rd., 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CORONARY ARTERY DISEASE

Approximate Interval Between Onset and Death

6 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

ESSENTIAL HYPERTENSION

25 YEARS

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown☐ Ectopic pregnancy☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D14160

29d. Date signed (Month, Day, Year)

JANUARY 30, 2008

30. Name and address of person who completed cause of death (Item 23b) (Type, Print)

MARJIT SINGH M.D. 5410-A RITCHIE HIGHWAY, BALTIMORE, MARYLAND 21225

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2008 02807

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Emma Jenkins

2. Date of Death  
Month Day Year

January 31, 2008

3. Time of Death

09:40 AM

4a. Facility Name (If not institution, give street and number)

332 East 21st Street

4b. City, Town, or Location of Death

Baltimore, MD 21218

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

217-16-3281

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

8. Date of Birth

12 4 13

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

332 East 21st Street

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5th Grade

College (1-4or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

House Keeping

16b. Kind of Business/Industry

Garrison Forest School

17. Father's Name (First, Middle, Last)

Emmett Wilkerson

18. Mother's Name (First, Middle, Maiden Surname)

Mary Footes

19a. Informant's Name/Relationship (Type, Print)

Bertha Jenkins

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

332 E. 21st Street Baltimore, MD 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Mem Park

Date

2/5/08

20c. Location - City or Town, State

Randallstown, MD

21. Signature of Funeral Service Licensee

Lynette K. Jones

22. Name and Address of Facility

March F/H East

1101 E. North Ave Baltimore, MD 21202

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arrhythmia

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Dementia

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

7 months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Heart murmur

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jerry Benson MD

29c. License number

D25373

29d. Date signed (Month, Day, Year)

February 4th, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jerry Benson MD, 2009 Druid Hill Ave, BALTO, MD 21217

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02808

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James E. Jones

2. Date of Death

01 29 08

3. Time of Death

19:20 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

252-24-1856

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

Nov. 3, 1924

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3716 Park Heights Ave.

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chef

16b. Kind of Business/Industry

Restuarant

17. Father's Name (First, Middle, Last)

John Jones

18. Mother's Name (First, Middle, Maiden Surname)

Henrietta Matthews

19a. Informant's Name/Relationship (Type, Print) (son)

Mr. Michael Jones

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11014 Kent Ave. Balto, Md. 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Holiness Mem.

Date

2/4/2008

20c. Location - City or Town, State

Butler, New Jersey

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home P.A.  
2222 W. North Ave. Balto, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. unsepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. acute renal failure

Due to (or as a consequence of):

7 days

c. hypertension

Due to (or as a consequence of):

5 days

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. P. P. P.

29c. License number

AT 2438946-1110

29d. Date signed (Month, Day, Year)

01/29/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. P. P. P., Union Memorial Hospital, Baltimore MD

31. Date filed (Month, Day, Year)

FEB 0 4 2008

32. Registrar's Signature

J. P. P. P.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02809

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Jordan

2. Date of Death  
Month Day Year  
01 29 20083. Time of Death  
12:04 A M

4a. Facility Name (If not institution, give street and number)

Harborside Healthcare Harford

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director5. Social Security Number  
213-88-61816. Sex  
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)  
43 Yrs.8. Date of Birth (Month, Day, Year)  
April 13, 19599. Birthplace (State or Foreign Country)  
MD

Usual Residence of Decedent

10a. State  
MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number

26 Cedar Heights Court #B

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S. Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian, Black, White, etc.  
African American  
Specify:

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unk

16b. Kind of Business/Industry  
unk

17. Father's Name (First, Middle, Last)

Joseph High

18. Mother's Name (First, Middle, Maiden Surname)

Gloria Jordan

19a. Informant's Name/Relationship (Type, Print)

Charles Johnson, 3rd / Uncle

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26 Cedar Heights Avenue #B; Baltimore, MD 21207

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

01/30/2008

20c. Location - City or Town, State

Catonsville, Maryland

21. Signature of Funeral Service Licensee

J. J. Jones

22. Name and Address of Facility

Wylie Funeral Home, P.A.

638 N. Gilmor Street; Baltimore, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrest  
Due to (or as a consequence of):b. End stage Renal disease  
Due to (or as a consequence of):c. HIV infection  
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hepatitis C, aortic valve  
Endocarditis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. J. Jones MD

29c. License number

64493

29d. Date signed (Month, Day, Year)

01-29-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johana Dange 821 N. Eutaw Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

J. J. Jones

State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02810

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Richard Leroy Lawrence</b>  |  | 2. Date of Death<br>Month <b>Feb</b> Day <b>3</b> Year <b>2008</b>  |  | 3. Time of Death<br><b>12:15 A<sup>M</sup></b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Carroll Hospital Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Westminster</b>  |  | 4c. County of Death<br><b>Carroll</b>  |  |
| 5. Social Security Number<br><b>316-36-5558</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Apr 23, 1942</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Indiana</b> |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Carroll</b>  | 10c. City, Town or Location<br><b>Taneytown</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>4317 Old Taneytown Rd.</b>  |  | 10f. Zip Code<br><b>21787</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1959-</b><br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Salesman</b>   |  |
| 16b. Kind of Business/Industry<br><b>Automobile</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Russell Lawrence</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elnyth Winestock</b>   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Deborah David (Daughter)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>38 Navesink Dr. Pennington, NJ 08534</b>  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>S. Carroll Crem</b>  |  | 20c. Location - City or Town, State<br><b>Winfield, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Burrier-Queen Funeral Home and Crematory, P.A.<br/>1212 W. Old Liberty Rd. Winfield, MD 21784</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CARDIAC ARREST</b><br><b>ATHEROSCLEROSIS</b>   |  |   |  |  |  |
| 23b. Immediate Cause (Final disease or condition resulting in death)<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):   |  |   |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |  |   |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>RHABDO MYOLYSIS</b><br><b>DISSEMINATED COAGULOPATHY</b>   |  |   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D29246</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2-3-08</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RITA PARA, Naturalist 2201 Washington Hots Westminster, MD 21157</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b>  |  | 32. Registrar's Signature<br>  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02811

1- For State Registrar Amend #17, per FH, G876, 2/4/08 T1 Certificate of Death

Reg. No.

|  |   |  |   |   |  |  |
|--|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Gerald J Lee</b>   |  | 2. Date of Death<br>Month <b>01</b> Day <b>28</b> Year <b>2008</b>  |   | 3. Time of Death<br><b>5:05 AM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Baltimore VA Medical Center</b>  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |   | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>086-30-9960</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Mar. 4, 1941</b>                                  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>                                    |  |
|  | Usual Residence of Decedent   |  |   |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>N/A</b>  | 10c. City, Town or Location<br><b>Baltimore</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>3801 Wabash Avenue #1C</b>   |  | 10f. Zip Code<br><b>#1C</b>   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1961-1965</b> | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>   |   | 16b. Kind of Business/Industry<br><b>City of Paterson, New Jersey</b>                          |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Merrell C. Washington</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Iona Lee</b>                        |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ethel Lee/ Wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3801 Wabash Avenue #1C Baltimore, Maryland 21215</b>  |   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenmount Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                              |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  | 22. Name and Address of Facility<br><b>Chatman-Harris Funeral Home<br/>5240 Reisterstown Rd Baltimore, Md 21215</b>   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause - (Final disease or condition resulting in death)<br>a. <b>Cardiomyopathy</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)  | 28b. Time of Injury<br>M  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |   |  |  |
| 29b. Signature and title of certifier<br><b>Thomas J. Merkle, M.D.</b>   |   | 29c. License number<br><b>NPI 1770786394</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>01-28-2008</b>                                    |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Thomas J. Merkle, M.D. 10N. Greene Street, Baltimore, MD 21201</b>  |   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b>  |   | 32. Registrar's Signature<br><i>[Signature]</i>  |   |   |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #8, per FH, g876, 2/4/08 TT Certificate of Death

Reg. No.

2008 02812

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JOHN LANEHART</b>  |  | 2. Date of Death<br>Month Day Year<br><b>JANUARY 28th 2008</b>  |  | 3. Time of Death<br><b>8:50 PM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>UNIVERSITY OF MARYLAND MEDICAL CENTER</b>  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>N/A</b>  |  |
| 5. Social Security Number<br><b>212-28-0897</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   |  |
| 8. Date of Birth<br>Month Day Year<br><b>June 3, 1928</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  | 10. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Pasadena</b>   |  |
| 10e. Street and Number<br><b>8569 Neptune Dr,</b>   |  | 10f. Zip Code<br><b>21122</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Painting Contractor</b>  |  |
| 16b. Kind of Business/Industry<br><b>Painting</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Carl H. Lanehart</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nora Schanell</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Beatrice V. Lanehart Spouse</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8569 Neptune Dr. Pasadena, MD 21122</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Good Shepherd Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Feb 02, 2008 Ellicott City, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043</b>   |  | 22. Name and Address of Facility  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>BACTEREMIA</b><br>Due to (or as a consequence of):<br>b. <b>PNEUMONIA</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown   |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CONGESTIVE HEART FAILURE</b><br><b>PULMONARY HYPERTENSION</b>  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |
| 29b. Signature and Title of certifier<br><b>Meena V Shah MD</b>   |  | 29c. License number<br><b>P18559</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>January 28, 2008</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Meena V Shah, MD 22 South Green Street Baltimore, MD 21201</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02813

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Locklear

2. Date of Death  
Month Day Year

February 1, 2008

3. Time of Death

0535 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris - Dulaney Valley

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

241-50-9005

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

8. Date of Birth (Month, Day, Year)

06/08/1936

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8182 N. Boundary Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: American Indian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

4

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assembly Worker

16b. Kind of Business/Industry

Automotive Factory

17. Father's Name (First, Middle, Last)

Clarence Locklear

18. Mother's Name (First, Middle, Maiden Surname)

Zebr Jones

19a. Informant's Name/Relationship (Type, Print)

Jeanette Walker - Executrix

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

211 South Broadway Baltimore, Maryland 21231

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Flam Cemetery

Date

02/05/2008

20c. Location - City or Town, State

Red Springs, North

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

David J. Weber Funeral Homes P.A.  
401 S. Chester Street Baltimore, Maryland 21231

Carolina

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Colon Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

2/1/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 Dulaney Valley Rd Timonium, MD 21043

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

State  
RegistrarFEBRUARY 1, 2008 5:35 AM  
Baltimore, Maryland 21215-0036To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitTHOMAS LOCKLEAR  
Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02814

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROSE

Y

LIEBERMAN

2. Date of Death  
Month Day Year  
January 30 20083. Time of Death  
4:05 PM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-12-8423

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

8. Date of Birth (Month, Day, Year)

06/19/1924

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1 POMONA EAST, #311

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

MAX

18. Mother's Name (First, Middle, Maiden Surname)

SHAROKY

SOPHIE

ALTER

19a. Informant's Name/Relationship (Type, Print)

JEFFREY LIEBERMAN / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11007 VALLEY HEIGHTS DRIVE, OWINGS MILLS, MD 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WORKMEN CIRCLE

Date

02/01/2008

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Matt Lee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.  
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Burkitt's lymphoma CNS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Right ocular lymphoma

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
3 months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dana Poun MD

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

January 30, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dana Poun, MD Sinai Hospital of Baltimore, 2401 West Belvedere Ave, Baltimore Maryland 21215

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02815

Physician/  
Medical Examiner1- For State  
RegistrarFuneral  
Director

|  |  |  |   |   |   |
|--|--|--|---|---|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Antonio Martinez-Martinez</b>   |  | 2. Date of Death<br>Month Day Year<br><b>January 28, 2008</b>  |   | 3. Time of Death<br><b>0610 hrs</b>   |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>I-95 SB @ Mile 86.5</b>   |  | 4b. City, Town, or Location of Death<br><b>Aberdeen</b>  |   | 4c. County of Death<br><b>Harford</b>   |   |
| 5. Social Security Number<br><b>N/A</b>  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (in yrs. last birthday)<br><b>28</b> Yrs.   | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br><b>Jan. 17, 1980</b>   | 9. Birthplace (State or Foreign Country)<br><b>Mexico</b>   |
| Usual Residence of Decedent  |  | 10c. City, Town or Location  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                              |   |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>N/A</b>  | <b>Baltimore</b>   |   |   |   |
| 10e. Street and Number<br><b>7001 Fieldcrest Road</b>  |  | 10f. Zip Code<br><b>21215</b>  |   | 10g. Citizen of What Country?<br><b>Mexico</b>  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>Mexican</b> |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th grade</b><br>College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cement Finisher</b>  |   | 16b. Kind of Business/Industry<br><b>Construction</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Celso Martinez</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Maria Martinez</b>  |   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Tereso Ramos /Uncle-in-law</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>21117 9547 Winands Road Owings Mills, Maryland</b>   |   |   |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>LaGranga Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>Unk. Simon Bolivar, DGO</b>   |   |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><b>Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215</b>  |   |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED |  |  |   |   | Approximate Interval Between Onset and Death  |
| 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown  |  |  |   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |
| 23d. Date of delivery<br>Month Day Year  |  |  |   |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |   |   |   |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br><b>Jan 28, 2008</b>  | 28b. Time of Injury<br><b>0600 hrs</b>    | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                 | 28d. Describe how injury occurred<br><b>Driver in auto to fixed object collision</b>  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Interstate/Express</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>I-95 NB @ Mile 86.5, Aberdeen, MD</b>   |   |   |   |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |   |   |
| 29b. Signature and title of certifier<br><i>[Signature]</i><br><b>Pamela E. Southall, MD</b>   |  | 29c. License number<br><b>O.C.M.E.</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>January 28, 2008</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>  |  |  |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>  |   |   |   |

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
Medical Examiner

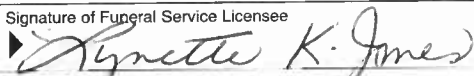
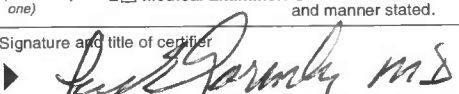
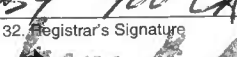
Division of Vital Records, P.O. Box 68760,  
The law requires that the death certificate be executed within 24 hours after death.  
To the Hospital or Attending Physician: After this certificate has been signed by the attending physician and to the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Reg. No. 2008-02816

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Abner William McCorkle Jr.</b>  |  | 2. Date of Death<br>Month <b>1</b> Day <b>31</b> Year <b>08</b>   |  | 3. Time of Death<br><b>10:50pM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Joseph Richey House</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>NA</b>   |  |
| 5. Social Security Number<br><b>212-80-9807</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>46</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>10 12 61</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>NA</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |  |
| 10e. Street and Number<br><b>6213 Shipview Way</b>   |  | 10f. Zip Code<br><b>21224</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A</b>  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 th Grade</b><br>College (1-4or 5+) <b>A A Degree</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Chef</b>                          |  | 16b. Kind of Business/Industry<br><b>Unk</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Abner W. McCorkle</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillie Williamson</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sister in Law Gertrune McCorkle-Marksey</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>638 W. Kingway Rd. Baltimore, MD 21220</b>    |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenmount Cem</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>March F/H East 1101 E. North Ave Baltimore, MD 21202</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>HIV/AIDS, End stage disease</b>  |  |   |  |  |  |
| 23b. Immediate Cause (Final disease or condition resulting in death)<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):   |  |   |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |  |   |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>   |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D18587</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>Feb 1 2008</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PAUL GORMLEY 900 CATON AVE BALTO MD 21229</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b>  |  | 32. Registrar's Signature<br>                                  |  |  |  |

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician  
/Medical  
Examiner

### **Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**Division or Vital Records, P.O. Box 68760,**

3

**State  
Registrar**

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02817

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Charles Bruce Morris

2. Date of Death

February 1 2008

3. Time of Death

5:36 PM

4a. Facility Name (If not institution, give street and number)

Baltimore Washington Medical Center

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

075-30-7301

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

8. Date of Birth

Oct 16, 1937

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Gambrills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2262 Mistwood Circle

10f. Zip Code

21054

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Civil Service

16b. Kind of Business/Industry

Centers for Medicare &amp; Medicaid

17. Father's Name (First, Middle, Last)

Charles Kasile Morris

18. Mother's Name (First, Middle, Maiden Surname)

Christine Leonhardt Baum

19a. Informant's Name/Relationship (Type, Print)

Henry Craig Morris/brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

305 Deerfield Road Newark, Delaware 19713

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington Nat Cemetery 3/18/2008

Date

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee

Quanta R Thomas

22. Name and Address of Facility

Donaldson Funeral Home & Crematory, P.A.  
1411 Annapolis Road Odenton, Maryland 21113

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure

Due to (or as a consequence of):

b. Anoxic encephalopathy

Due to (or as a consequence of):

c. Aspiration pneumonia

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Samir Jain MD

29c. License number

D0061832

29d. Date signed (Month, Day, Year)

February 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMIR JAIN 301 Hospital Drive Glen Burnie, Maryland 21061

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Morris, Charles  
 Baltimore, Maryland 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02818

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY L. MCDONALD

2. Date of Death

Month Day Year  
JAN 29 2008

3. Time of Death

8:32 P M

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

019-20-9720

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
04-04-1927

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Odenton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1905 Battle Way

10f. Zip Code

21113

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Telecommunication Specialist

16b. Kind of Business/Industry

U. S. Government

17. Father's Name (First, Middle, Last)

Edward J. Ledvina

18. Mother's Name (First, Middle, Maiden Surname)

Mary C. Sylvia

19a. Informant's Name/Relationship (Type, Print)

Joe Henry McDonald / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1905 Battle Way Odenton, Maryland 21113

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington Nat. Ceme.

Date

2-11-2008

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donaldson Funeral Home & Crematory, P.A.  
1411 Annapolis Road Odenton, Maryland 21113

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. DIFFUSE LARGE B CELL LYMPHOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

0101240316 (VA)

29d. Date signed (Month, Day, Year)

January 30, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN P. ARMBRUSTER LT MC USN

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
RegistrarReg. No. 2008 02819  
3. Time of Death 6:05PMPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HENRY T. MCFADDEN

2. Date of Death  
Month Day Year  
JANUARY 31, 2008Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MANOR CARE TOWSON

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

030-10-8337

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth (Month, Day, Year)

5/27/1920

9. Birthplace (State or Foreign Country)

MASSACHUSETTS

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

204 E. JOPPA ROAD PH17

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: WHITE15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

MERCHANT SEAMAN

16b. Kind of Business/Industry

UNION

17. Father's Name (First, Middle, Last)

HENRY MCFADDEN

18. Mother's Name (First, Middle, Maiden Surname)

NELLIE WELBY

19a. Informant's Name/Relationship (Type, Print)

EMMA G. MCFADDEN/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

204 E. JOPPA ROAD PH17 TOWSON, MD 21286

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

METRO CREMATORY, INC.

Date

2/2/2008

20c. Location - City or Town, State

CATONSVILLE, MD

21. Signature of Funeral Service Licensee

Heath Hay Johnson

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.  
8521 LOCH RAVEN BLVD. TOWSON, MD 2128623a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CEREBROVASCULAR THROMBOSIS

Due to (or as a consequence of):

and STROKE

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A-H. GHALADI, M.D.

29c. License number

D-0012849

29d. Date signed (Month, Day, Year)

2-1-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A-H. GHALADI, M.D. 7600 OSTER DR. TOWSON MD 21204

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

Heath Hay Johnson

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

John Jerry Moore

2. Date of Death

January 24, 2008

3. Time of Death

1:00 AM

4a. Facility Name (If not institution, give street and number)

Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

5. Social Security Number

213-24-0024

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

8. Date of Birth (Month, Day, Year)

10/28/1929

9. Birthplace (State or Foreign Country)

Salisbury, MD

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Whaleyville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8035 Old Ocean City Road

10f. Zip Code

21872

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1964

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

US Marine Corp

16b. Kind of Business/Industry

US Government

17. Father's Name (First, Middle, Last)

Henry Lane

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Lane

19a. Informant's Name/Relationship (Type, Print)

Myrtle Moore/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8035 Old Ocean City Road

Whaleyville, MD 21872

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Howard University

Date

1/28/08

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Austin Royster Funeral Home

3821 14th Street, N.W., Washington, DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

064585

29d. Date signed (Month, Day, Year)

1/24/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony Perez 9733 Hookway Drive Berlin MD 21811

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02821

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Angelina Ann Maggio

2. Date of Death  
Month Day Year

Jan 29, 2008

3. Time of Death

7:30 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Clifton Woods Assisted Living

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

089-34-4640

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

8. Date of Birth (Month, Day, Year)

Aug 30, 1917

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Clarksville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6032 Winter Grain Path

10f. Zip Code

21029

10g. Citizen of What Country?

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

Local Government

17. Father's Name (First, Middle, Last)

Daniel Cimielli

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Caraccio

19a. Informant's Name/Relationship (Type, Print)

Robert Maggio

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6032 Winter Grain Path Clarksville, MD 21029

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

All County Cremation Services

Date

Jan 30, 2008

20c. Location - City or Town, State

Sykesville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Slack Funeral Home, P.A.  
3871 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiomyopathy

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

b. Coronary Artery Disease

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia  
Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Assisted Living

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D32332

29d. Date signed (Month, Day, Year)

Jan 30, 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh K. Gupta MD 9801 Georgia Ave Silver Spring MD 20902

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02822

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Merle Meyer

2. Date of Death

01 31 08

3. Time of Death

7:15A

4a. Facility Name (If not institution, give street and number)

Transitions Health Care

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

218-10-3505

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb 26 1921

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

PA

10b. County

Adams

10c. City, Town or Location

Biglerville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

260 Winding Brook Road

10f. Zip Code

17307

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

secretary

16b. Kind of Business/Industry

office management

17. Father's Name (First, Middle, Last)

Arthur W. Hall

18. Mother's Name (First, Middle, Maiden Surname)

Gellia M. Morris

19a. Informant's Name/Relationship (Type, Print)

Wayde Meyer (stepson)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

260 Winding Brook Rd., Biglerville, PA 17307

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park Cemetery

Date

2-5-08

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

► Paige Haight Sterbert

22. Name and Address of Facility

Haight Funeral Home & Chapel  
P.O. Box 195 Sykesville, MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Bacterial Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► [Signature]

29c. License number

D43725

29d. Date signed (Month, Day, Year)

2/1/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD 19 Ridge Road Westminster 21157

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 1 per dr. 887703/05/08dmh

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

1- For State Registrar

Reg. No. 2008 02823

Physician /Medical Examiner

Funeral Director

|   |  |   |   |   |
|---|--|---|---|---|
| 1. Decedent's Name (First, Middle, Last) <b>Jessie Nealy</b>  |  | 2. Date of Death<br>Month <b>JANUARY</b> Day <b>29</b> Year <b>2008</b>   |   | 3. Time of Death<br><b>0115A<sup>M</sup></b>  |
| 4a. Facility Name (If not institution, give street and number)<br><b>EASTON MEMORIAL HOSPITAL</b>   |  | 4b. City, Town, or Location of Death<br><b>EASTON</b>   |   | 4c. County of Death<br><b>TALBOTT</b>   |
| 5. Social Security Number<br><b>217-24-3544</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Dec 4, 1930</b>                   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |
| Usual Residence of Decedent   |  |   |   |   |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>Anne Arundel</b>   | 10c. City, Town or Location<br><b>Severna Park</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 10e. Street and Number<br><b>357 Jennings Road</b>  |  | 10f. Zip Code<br><b>21146</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>nursing aide</b>  |   | 16b. Kind of Business/Industry<br><b>healthcare</b>   |
| 17. Father's Name (First, Middle, Last)<br><b>Frank Williams</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie Jennings</b> |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Easton Memorial Hospital</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>219 S. Washington Street Easton MD 21601</b>  |   |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |   | 20c. Location - City or Town, State   |
| 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>  |  | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>  |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>ACUTE MYOCARDIAL INFARCTION</b><br>Approximate Interval Between Onset and Death<br><b>3 HOURS</b>  |  |   |   |   |
| 23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>TYPE 2 DIABETES MELLITUS</b><br><b>END STAGE RENAL DISEASE</b><br><b>HYPERTENSION</b>  |  |   |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)    |   |   |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  | 28b. Time of Injury<br>M  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |   |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |   |
| 29b. Signature and title of certifier<br><b>[Signature]</b>   |  | 29c. License number<br><b>D46360</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>JANUARY 29, 2008</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MICHAEL A. ANKRAM MD 8601 Veterans Highway Millersville MD 21108</b>   |  |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |   |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend items 20a-c, 22 per fh 8876 2-4-08 yt

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2008 02824

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>DANIEL PELTZER</b>   |  | 2. Date of Death<br>Month <b>01</b> Day <b>23</b> Year <b>08</b>  |  | 3. Time of Death<br><b>3:50AM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>FUTURECARE CHERRYWOOD</b>  |  | 4b. City, Town, or Location of Death<br><b>REISTERSTOWN</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>   |  |
| 5. Social Security Number<br><b>215-32-1403</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br><b>Mar 16, 1935</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Hampstead</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>1719 Broadbeck Road</b>  |  | 10f. Zip Code<br><b>21074</b>   |  |
| 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4or 5+) <b>0</b>   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>plumbers helper</b>   |  | 16b. Kind of Business/Industry<br><b>unk</b>  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Spurgeon Peltzer</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Grace Helwig</b>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Lawrence Peltzer/brother</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1719 Broadbeck Road Hampstead, MD 21074</b>   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>                                |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>All Saints Cem.</b>  |  | 20c. Location - City or Town, State<br><b>2-5-08 Reisterstown, Md.</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>  |  | 21a. Signature of State Anatomist<br><b>Elaine Russell</b>  |  | 21b. Address of State Anatomist<br><b>11824 Reisterstown Rd Baltimore, MD 21201</b>   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Colon Ca</b> |  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown  |  |
| 23d. Date of delivery<br>Month Day Year   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                         |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Allen Nettleson</b>   |  |
| 29c. License number<br><b>P27569</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>11/28/08</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>1838 Greene Tree Rd 21208</b>  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b>   |  | 32. Registrar's Signature<br><b>James B. Spivey</b>   |  |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

2



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Amend 5, 19a, per H, 8876, 2/4/08 IT  
State Registrar

Certificate of Death

Reg. No.

2008 02825

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><i>Reginald Richardson</i>   |  | 2. Date of Death<br>Month <i>01</i> Day <i>27</i> Year <i>08</i>  |  | 3. Time of Death<br><i>8:30 A M</i>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><i>Ravenwood Nursing Home</i>  |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>  |  | 4c. County of Death<br><i>Baltimore City</i>   |   |
| 5. Social Security Number<br><i>217-68-4859</i>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>42</i> Yrs. | 8. Date of Birth (Month, Day, Year)<br><i>June 26, 1965</i>  | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i> |
| 10a. State<br><i>Maryland</i>  |  | 10b. County<br><i>N/A</i>   |  | 10c. City, Town or Location<br><i>Baltimore</i>  |   |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><i>1012 Pennsylvania Avenue #202</i>  |  | 10f. Zip Code<br><i>21201</i>  |   |
| 10g. Citizen of What Country?<br><i>USA</i>  |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:      |   |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>   |  | 15. Decedent's Education (Specify only highest grade completed)<br><i>10th grade</i>   |   |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Laborer</i>  |  | 16b. Kind of Business/Industry<br><i>Private Industry</i>   |  | 17. Father's Name (First, Middle, Last)<br><i>Willie Richardson</i>  |   |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Odell Hendricks</i>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Odell Richardson/ Mother</i>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1012 Pennsylvania Ave #202 Baltimore, Md 21201</i> |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Mt. Zion Cemetery</i>  |  | 20c. Location - City or Town, State<br><i>Lansdowne, Maryland</i>  |   |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><i>Chatman-Harris Funeral Home<br/>5240 Reisterstown Rd Baltimore, Md 21215</i>   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. AIDS</i><br>Due to (or as a consequence of):<br><i>b. Due to (or as a consequence of):</i><br><i>c. Due to (or as a consequence of):</i><br><i>d. Due to (or as a consequence of):</i> |  |   |  |  |   |
| Approximate Interval Between Onset and Death<br><i>10 Years</i>  |  |   |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  |   |  |  |   |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |  |   |  |  |   |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Encephalopathy, malnutrition</i>  |  |   |  |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |   |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |  | 29c. License number<br><i>043386</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>113008</i>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Daniel R. Howard 1714 Ectaw Place, Baltimore, MD 21217</i>  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><i>FEB 04 2008</i>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02826

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

STELLA S. ROWLAND

2. Date of Death

JANUARY 31, 2008

3. Time of Death

10:10 PM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

329-16-2660

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth (Month, Day, Year)

12/2/1922

9. Birthplace (State or Foreign Country)

CHICAGO, IL

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

975 FAIRMOUNT AVENUE

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NURSE AID

16b. Kind of Business/Industry

HOSPITAL

17. Father's Name (First, Middle, Last)

JOSEPH SORDYL

18. Mother's Name (First, Middle, Maiden Surname)

VICTORIA SPICEK

19a. Informant's Name/Relationship (Type, Print)

STEVEN ROWLAND/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

975 FAIRMOUNT AVENUE TOWSON, MD 21204

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY, INC.

Date

2/4/2008

20c. Location - City or Town, State

CATONSVILLE, MD

21. Signature of Funeral Service Licensee

Heath Hay-Larison

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.  
8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Approximate Interval Between Onset and Death

10+ YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

DEMENTIA

2 YEARS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mien-Door Kioone, MD

29c. License number

D31865

29d. Date signed (Month, Day, Year)

2/1/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIEN-DOOR KIOONE M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

Heath Hay-Larison

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02827

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY BARNES REID

2. Date of Death  
Month Day Year  
FEBRUARY 1 20083. Time of Death  
2:28 A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

UPPER CHESAPEAKE HOSPITAL

4b. City, Town, or Location of Death

BEL AIR

4c. County of Death

HARFORD

Funeral  
Director

5. Social Security Number

250-84-6059

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

8. Date of Birth (Month, Day, Year)

04-29-1929

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

DUNDALK

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6840 BROENING RD

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

06

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COOK

16b. Kind of Business/Industry

SCHOOL SYSTEM

17. Father's Name (First, Middle, Last)

LEROY BARNES

18. Mother's Name (First, Middle, Maiden Surname)

LOU INGRAM

19a. Informant's Name/Relationship (Type, Print)

NANCY G. REID/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6840 BROENING RD, DUNDALK, MD 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. PAUL CHURCH CEM.

Date

02-06-2008

20c. Location - City or Town, State

LANCASTER, SC

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

JAMES A. MORTON &amp; SONS F.H., INC

1701 LAURENS ST., BALTO., MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Cerebral Infarct

Approximate Interval Between Onset and Death  
1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Kevin Lynett

29c. License number

D35012

29d. Date signed (Month, Day, Year)

02/01/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Kevin Lynett MD Upper Chesapeake Hospital Bel Air, MD 21014

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

J. Kevin Lynett

State  
RegistrarBaltimore, Maryland 21215-0036  
0228 AM M-800 484 754  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02828

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary E. Robinson

2. Date of Death  
Month Day Year

JANUARY 29 2008

3. Time of Death

4:40 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE City

5. Social Security Number

216-24-5379

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

8. Date of Birth

Feb. 23, 1929

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2714 Jefferson St.

10f. Zip Code

21205

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cafeteria Aide

16b. Kind of Business/Industry

School System

17. Father's Name (First, Middle, Last)

Robert Kelly

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Holder Kelly

19a. Informant's Name/Relationship (Type, Print) (Son)

Mr. Letmon Blue

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6110 Plantview Way, Balto. Md. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crownsville VA Cem.

Date

2/6/2008

20c. Location - City or Town, State

Crownsville, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home, P.A.

2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTIC SHOCK

Due to (or as a consequence of):

b. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

c. LARYNGEAL CARCINOMA

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

1/29/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAMS QUAZI, GOOD SAMARITAN HOSPITAL, 5601 LOCHRAVEN BLVD. BALTIMORE MD 21286

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

State  
Registrar

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02829

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Lorenzo Sembly, Jr.

2. Date of Death

Jan. 24, 2008

3. Time of Death

10:41A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

5220 York Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

213-46-2210

6. Sex

M 2 F

7. Age (In yrs. last birthday)

64

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth (Month, Day, Year)

Apr. 30, 1943 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

X Yes 2 No

10e. Street and Number

5220 York Road Apt. J8

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1 Year

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Warehouseman

16b. Kind of Business/Industry

Filter Rite

17. Father's Name (First, Middle, Last)

Richard L. Sembly, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Frances Minor

19a. Informant's Name/Relationship (Type, Print)

Latasha Beale/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

721 N. Luzerne Ave Baltimore, Maryland 21205

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Cemetery

Date

1/28/08

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Chatman-Harris Funeral Home  
5240 Reisterstown Rd Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ATHERO SCLEROSIS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 Yes 2 No  
9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy  
4 Pregnant at time of death 5 Other (specify)  
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE  
ATRIAL FIBRILLATION

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D37280

29d. Date signed (Month, Day, Year)

1/28/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jerald Insal, MD 5601 Loch Raven Blvd Baltimore Md 21234

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No.

2008 02830

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD

STOLZENBACH

2. Date of Death

Month Day Year

JANUARY 29 2008

3. Time of Death

9:35 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL  
3001 SOUTH HANOVER STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

5. Social Security Number

214-16-8771

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
7/15/1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3203 Janice Avenue

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10College (1-4or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Warehousemen

16b. Kind of Business/Industry

Paper

17. Father's Name (First, Middle, Last)

Edward Stolzenbach

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Umbridge

19a. Informant's Name/Relationship (Type, Print)

Louis C. Thompson / Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5713 Redmond Street, Baltimore, MD 21225

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Loudon Park Ceme.

Date

2/2/2008

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service licensee

22. Name and Address of Facility

Hubbard Funeral Home, Inc.

4107 Wilkens Avenue, Baltimore, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. PNEUMONIA

Approximate  
Interval Between  
Onset and Death

5 DAYS

Due to (or as a consequence of):

b. METASTATIC LUNG CANCER

3 MONTHS

Due to (or as a consequence of):

c. DEEP VEIN THROMBOSIS

5 DAYS

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)  
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown24a. Was an  
autopsy  
performed?  
☐ Yes ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
☐ Yes ☒ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

M.D.

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

JANUARY 29 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OYISE IHEAGWARA, 3001 SOUTH HANOVER STREET, BALTIMORE, MARYLAND 21225

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02831

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARTHA VIRGINIA STEM

2. Date of Death

Month Day Year  
FEB. 1, 2008

3. Time of Death

12:30 A<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

CARROLL HOSPICE DOVE HOUSE

4b. City, Town, or Location of Death

WESTMINSTER

4c. County of Death

CARROLL

5. Social Security Number

214-28-1085

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
3/15/1931

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

CARROLL

10c. City, Town or Location

WESTMINSTER

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

237 HOOK RD.

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

OWNER

16b. Kind of Business/Industry

PRINTING

17. Father's Name (First, Middle, Last)

JOHN WILLIAM HARRIS

18. Mother's Name (First, Middle, Maiden Surname)

MAMIE MARIE MILLER

19a. Informant's Name/Relationship (Type, Print)

CHARLES W. STEM -HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

237 HOOK RD., WESTMINSTER, MD 21157

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

ENTOMBMENT EVERGREEN MEM.GARDENS

Date  
2/4/08

20c. Location - City or Town, State

FINKSBURG, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A.

254 E. MAIN ST., WESTMINSTER, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic Adenocarcinoma of the Colon

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
3 YEARSSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D17040

29d. Date signed (Month, Day, Year)

FEBRUARY 1, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOWARD G. LANHAM, M.D. 215 WASHINGTON HEIGHTS MEDICAL CENTER

WESTMINSTER, MD 21157

31. Date filed (Month, Day, Year)

FEB 4 2008

Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar amend #8 Per Inf G876 2/22/08 Certificate of Death

Reg. No.

2008 02832

|  |   |  |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Hutao Shan</b>                                     |  |  |  | 2. Date of Death<br>Month Day Year<br><b>Feb 1, 2008</b> |  | 3. Time of Death<br><b>7:52 A<sup>M</sup></b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Gilchrist Hospice Center</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Towson</b>    |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-59-3437</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan 05, 1933</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>China</b>     |
|  | Usual Residence of Decedent   |  |  |  |  |  |  |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Howard</b>   |  | 10c. City, Town or Location<br><b>Ellicott City</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>13306 Royden Court</b>  |   |  |  | 10f. Zip Code<br><b>21042</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Chinese</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+)  |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Professor</b>  |  | 16b. Kind of Business/Industry<br><b>Education</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Fengming Shan</b>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Feng Li</b>  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jie Shan</b>  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13306 Royden Ct. Ellicott City, MD 21042</b>   |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>All County Cremation Services</b>   |  | Date<br><b>Feb 04, 2008</b>  |  | 20c. Location - City or Town, State<br><b>Sykesville, Maryland</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   |  |  | 22. Name and Address of Facility<br><b>Slack Funeral Home, P.A.<br/>3871 Old Columbia Pike Ellicott City, MD 21043</b>   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>prostate cancer</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>years</b> |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input checked="" type="checkbox"/> Other (specify)   |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>hospice</b> |  |  |  |  |  |  |
| 27. Manner of death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                            |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   | 29b. Signature and title of certifier<br><i>[Signature]</i>  |  | 29c. License number<br><b>D58303</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 1 2008</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>AARON J. CHARLES MD 6701 N. CHARLES ST TOWSON MD 21204</b>  |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b>  |   | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02833

1- For State Registrar Amend #30 per DVR, g876, 2/4/08 TT Certificate of Death

Reg. No.

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>John J. Serafinas</b>   |  | 2. Date of Death<br>Month Day Year<br><b>January 30, 2008</b>   |  | 3. Time of Death<br><b>1040 p</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>National Lutheran Home</b>  |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>214-12-0589</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>04/25/1922</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  | 10c. City, Town or Location<br><b>Royd</b>               |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>20622 Topridge Road</b>   |  | 10f. Zip Code<br><b>21841</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Steel Worker</b>  |  | 16b. Kind of Business/Industry<br><b>Steel</b>   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Michael Serafinas</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Zelinski</b>   |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Michael Serafinas - Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>20622 Topridge Road Royd, Maryland 21841</b>  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematorium or other place)<br><b>Louisa Park Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>02/02/2008 Baltimore, Maryland</b>   |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><b>David J. Weber Funeral Homes P.A.<br/>5311 Edmondson Avenue Baltimore, Maryland 21229</b>  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><b>years</b><br><b>years</b><br><b>years</b>  |  |  |
| To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.               |  | 29c. License number<br><b>D21726</b>  |  |  |
|   | 29b. Signature and title of certifier<br><i>[Signature]</i>  |  | 29d. Date signed (Month, Day, Year)<br><b>January 31, 2008</b>  |  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Charles Karesh, MD National Lutheran Home</b>   |  | 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b>   |  |  |
|   | 32. Registrar's Signature<br><i>[Signature]</i>  |  |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02834

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Jesse Sellman Sp.

2. Date of Death

Month

Day

Year

3. Time of Death

11 P M

4a. Facility Name (If not institution, give street and number)

Kensington Nursing Home

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

5. Social Security Number

578-84-9875

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Sept 16, 1963

9. Birthplace (State or Foreign Country)

unk

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2000 McComas Avenue

10f. Zip Code

20895

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unk

College (1-4 or 5+)

unk

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

unk

16b. Kind of Business/Industry

unk

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

Kensington Nursing Home

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2000 McComas Avenue Kensington, MD 20895

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Huntington's Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dysphagia, G-tube feeding,  
Bilateral leg weakness,  
failure to thrive

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Chowdhury

29c. License number

D43121

29d. Date signed (Month, Day, Year)

1/29/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NURUL CHOWDHURY, MD 15216 Dino Drive, Burtonsville, MD 20866

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

John B. Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 505a.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008-02835

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>William R. Schwartz Jr</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>January 16, 2008</b>  |  | 3. Time of Death<br><b>5:00 PM M</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>10012 Shanktown Road</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Big Pool</b>  |  | 4c. County of Death<br><b>Washington</b>   |  |
| 5. Social Security Number<br><b>218-44-5261</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>May 31, 1947</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Washington</b>   |  | 10c. City, Town or Location<br><b>Big Pool</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>10012 Shanktown Road</b>   |  | 10f. Zip Code<br><b>21711</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b><br>College (1-4 or 5+) <b>0</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>caretaker</b>   |  | 16b. Kind of Business/Industry<br><b>unk</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Royston Schwartz</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Virginia Agnes Bosley</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Michelle Carr/niece</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10012 Shanktown Road Big Pool, MD 21711</b>  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |  | Date   |  | 20c. Location - City or Town, State  |  |
| 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>  |  | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street<br/>Baltimore, MD 21201</b>  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Liver cirrhosis</b><br>Due to (or as a consequence of):<br>a. <b>Liver cirrhosis</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  | Approximate Interval Between Onset and Death<br><b>Years</b> |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown                     |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Portal vein thrombosis</b><br><b>Depression</b><br><b>Deconditioning</b>   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Home address</b> |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred   |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>Lee, M.D. Primary Care physician</b>  |  |   |  | 29c. License number<br><b>D0063368</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>1/28/2008</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DONG HYUN LEE, M.D. 912 Seton Dr. Cumberland, MD 21502</b>   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |  |  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02836

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LUCILLE M. VICK

2. Date of Death

February 01, 2008

3. Time of Death

4:18P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

5. Social Security Number

215-28-7690

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

8. Date of Birth (Month, Day, Year)

AUGUST 31, 1922

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1129 N. FULTON AVENUE

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

HOMEMAKER

17. Father's Name (First, Middle, Last)

ARTIS JONES

18. Mother's Name (First, Middle, Maiden Surname)

PATTIE PULLEY

19a. Informant's Name/Relationship (Type, Print)

BEVERLY L. VICK /DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6617 EBERLY DRIVE APT. 202 BALTIMORE, MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE NATIONAL

Date

02-08-2008

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

JAMES A. MORTON &amp; SONS F.H., INC.

1701-31 LAURENS ST. BALTIMORE, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Renal Failure

Due to (or as a consequence of):

b. Acute Myocardial Infarction

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Raza Afzal

29c. License number

89589

29d. Date signed (Month, Day, Year)

February 01, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raza Afzal M.D., c/o Maryland General Hospital

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Lucille Vick

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02837

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Mary R. Williams

2. Date of Death  
Month Day Year

Jun 28 2008

3. Time of Death

15:38 M

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

244-48-7829

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

8. Date of Birth (Month, Day, Year)

May 6, 1932

9. Birthplace (State or Foreign Country)

North Carolina

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

837 Mt. Holly St.

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assembler

16b. Kind of Business/Industry

Westinghouse Corp.

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Surname)

unk Annie Wooten

19a. Informant's Name/Relationship (Type, Print) (Husband)

Mr. Willie J. Williams

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

837 Mt. Holly St. Balto. Md. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest

Date

2/7/2008

20c. Location - City or Town, State

Owings Mills, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home, P.A.  
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

30 min.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease, sp Renal Transplant

Hypertension, Diabetes

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph L. Russ MD

29c. License number

An 41176435P18314

29d. Date signed (Month, Day, Year)

Jan 28, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Adam Polifka 22 South Greene Street Baltimore, Md 21201

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene

2008 02838

1- For State Registrar

Certificate of Death

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last) James Courtney Walter  
2. Date of Death Month Day Year February 1, 2008  
3. Time of Death 0948 hrs

Funeral Director

4a. Facility Name (if not institution, give street and number) 116 Mike Court  
4b. City, Town, or Location of Death Elkton  
4c. County of Death Cecil

5. Social Security Number 611-07-5327  
6. Sex 1 ☒ M 2 ☐ F  
7. Age (In yrs. last birthday) 26 Yrs.  
8. Date of Birth (MM/DD/YYYY) 06/16/1981  
9. Birthplace (State or Foreign Country) NC

Usual Residence of Decedent  
10a. State MD  
10b. County Cecil  
10c. City, Town or Location Elkton  
10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number 116 Mike Court  
10f. Zip Code 21921  
10g. Citizen of What Country? USA

11. Marital Status 1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced  
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No  
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No specify:  
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10  
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bartender  
16b. Kind of Business/Industry Food Service

17. Father's Name (First, Middle, Last) William Joseph Walter  
18. Mother's Name (First, Middle, Maiden Surname) Phyllis Maria Wittik

19a. Informant's Name/Relationship (Type, Print) Shandi Walter / Sister  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2602 Ambler Road, Dundalk, MD 21222

20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other Specify:  
20b. Place of Disposition (Name of cemetery, crematory or other place) W. Arundel Crematory  
20c. Location - City or Town, State Odenton, MD  
20d. Date 02/04/2008

21. Signature of Funeral Service Licensee [Signature]  
22. Name and Address of Facility Rendon-Bailey Funeral Home, PA  
M01452 2818 E. Baltimore St., Baltimore, MD 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death) a. Cardiac arrhythmia  
Due to (or as a consequence of):  
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 ☐ Unknown  
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery Month Day Year  
23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No  
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No  
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined  
28a. Date of Injury (Month, Day, Year)  
28b. Time of Injury  
28c. Injury at Work? 1 ☐ Yes 2 ☐ No  
28d. Describe how injury occurred  
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier [Signature]  
29c. License number O.C.M.E.  
29d. Date signed (Month, Day, Year) February 2, 2008

30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) FEB 04 2008  
32. Registrar's Signature [Signature]

State Registrar

Division of Vital Records, P.O. Box 68760, Baltimore, MD 21268-0760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician Medical Examiner

Physician Medical Examiner

ORIGINAL


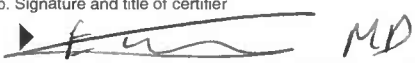

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02839

1- For  
State  
Registrar

|   |  |                                  |   |   |  |                                      |   |  |  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
|---|--|----------------------------------|---|---|--|--------------------------------------|---|--|--|-----------------------------------|--|--|--|----|----------------------------------|--|----|---------------------------------|----------------|----|----------------------------|--------------|----|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Ruth Virginia Younkings</b>   |                                  |   |   | 2. Date of Death<br>Month <b>February</b> Day <b>2</b> Year <b>2008</b>  |                                      |   |  | 3. Time of Death<br><b>16:32 PM</b>  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Saint Agnes Hospital</b>  |                                  |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |                                      |   |  | 4c. County of Death<br><b>n/a</b>  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-36-7310</b>  |                                  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.   |                                      | 8. Date of Birth (Month, Day, Year)<br><b>8/29/1939</b>                         |  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                                    |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
|   | Usual Residence of Decedent  |                                  |   |   |  |                                      |   |  |  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  |                                  | 10b. County<br><b>n/a</b>   |   | 10c. City, Town or Location<br><b>Baltimore</b>  |                                      |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
|   | 10e. Street and Number<br><b>2441 Ashton Street</b>  |                                  |   |   | 10f. Zip Code<br><b>21223</b>  |                                      |   |  | 10g. Citizen of What Country?<br><b>USA</b>  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                      |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                            |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>0</b>   |                                  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Supervisor</b>   |                                      |   |  | 16b. Kind of Business/Industry<br><b>Medical Supply</b>  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Leon W. Younkings, Sr.</b>   |                                  |   |   |  |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Yeatts Hoover</b> |  |  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gloria L. Bentley / Dau.</b>  |                                  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2441 Ashton St., Baltimore, MD 21223</b>   |                                      |   |  |  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |                                  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>  |                                      | Date<br><b>2/6/2008</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                                  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
|   | 21. Signature of Funeral Service Licensee<br>   |                                  |   |   | 22. Name and Address of Facility<br><b>Hubbard Funeral Home, Inc.<br/>4107 Wilkens Avenue, Baltimore, MD 21229</b>   |                                      |   |  |  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |                                  |   |   |  |                                      |   |  |  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
|   | <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Right basal ganglia bleed</b></td> <td>Approximate Interval Between Onset and Death<br/><b>one day</b></td> </tr> <tr> <td>b.</td> <td><b>Right frontal lobe bleed</b></td> <td><b>one day</b></td> </tr> <tr> <td>c.</td> <td><b>High blood pressure</b></td> <td><b>years</b></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> |                                  |   |   |  |                                      |   |  |  |                                   |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>Right basal ganglia bleed</b> | Approximate Interval Between Onset and Death<br><b>one day</b> | b. | <b>Right frontal lobe bleed</b> | <b>one day</b> | c. | <b>High blood pressure</b> | <b>years</b> | d. |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a.   | <b>Right basal ganglia bleed</b> | Approximate Interval Between Onset and Death<br><b>one day</b>  |   |  |                                      |   |  |  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
|   | b.   | <b>Right frontal lobe bleed</b>  | <b>one day</b>  |   |  |                                      |   |  |  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
|   | c.   | <b>High blood pressure</b>       | <b>years</b>  |   |  |                                      |   |  |  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
|   | d.   |                                  |   |   |  |                                      |   |  |  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  |                                  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |                                      |   | 23d. Date of delivery<br>Month Day Year  |  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                                  |   |   |  |                                      |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                                  |   |   |  |                                      |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                                  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                      |   |  |  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |                                  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M             |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
|   |  |                                  |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                      |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                                  |   |   |  |                                      |   |  |  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
| 29b. Signature and title of certifier<br> MD   |  |                                  |   |   |  | 29c. License number<br><b>P20966</b> |   | 29d. Date signed (Month, Day, Year)<br><b>February 2 2008</b>  |  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>900 S. Caton Ave., Baltimore, MD 21229</b>   |  |                                  |   |   |  |                                      |   |  |  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b>   |  |                                  |   | 32. Registrar's Signature<br>  |  |                                      |   |  |  |                                   |  |  |  |    |                                  |  |    |                                 |                |    |                            |              |    |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02840

1- For  
State  
Registrar

|  |   |  |  |  |   |   |  |   |   |   |  |   |  |  |  |
|--|---|--|--|--|---|---|--|---|---|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Dominic</b>  |  |  |  | 2. Date of Death<br>Month <b>January</b> Day <b>27</b> Year <b>2008</b>   |   |  |   | 3. Time of Death<br><b>1244 P M</b>                                     |   |  |   |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>The Johns Hopkins Hospital</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |   |  |   | 4c. County of Death   |   |  |   |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>620-98-7228</b>   |  | 6. Sex<br><b>1</b> M <b>2</b> F  |  | 7. Age (In yrs. last birthday)<br><b>10</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>Aug 11, 1997</b> |   | 9. Birthplace (State or Foreign Country)<br><b>California</b>           |   |  |   |  |  |  |
|  | Usual Residence of Decedent   |  |  |  |   |   |  |   |   |   |  |   |  |  |  |
| 10a. State<br><b>MD</b>  |   |  | 10b. County<br><b>Howard</b>   |  |   | 10c. City, Town or Location<br><b>Columbia</b>  |  |   | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No                     |   |  |   |  |  |  |
| 10e. Street and Number<br><b>9503 Gray Mouse Way</b>   |   |  |  |  | 10f. Zip Code<br><b>21046</b>   |   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |   |  |   |  |  |  |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates: |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>4</b> Elementary/Secondary (0-12) <b>College (1-4or 5+)</b>  |   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b>                           |   |  | 16b. Kind of Business/Industry<br><b>Elementary School</b>  |   |   |  |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Christopher John Zahlis</b>  |   |  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Andrea Marie Poulos</b>   |  |   |   |   |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Christopher J. Zahlis /father</b>   |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9503 Gray Mouse Way, Columbia, Maryland 21046</b> |   |  |   |   |   |  |   |  |  |  |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Union Cemetery</b>  |   | Date<br><b>Jan 31, 08</b>   |  | 20c. Location - City or Town, State<br><b>Burtonsville, Maryland</b>  |   |   |  |   |  |  |  |
| 21. Signature of Funeral Service Licensee<br><br><b>M00773</b>   |   |  |  |  | 22. Name and Address of Facility<br><b>Donaldson Funeral Home, P.A.<br/>313 Talbott Ave. Laurel, Maryland 20707-4389</b>                              |   |  |   |   |   |  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Severe brainstem hemorrhage</b><br>Due to (or as a consequence of):<br><b>b. new onset T cell leukemia</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |  |  |  |   |   |  |   |   | Approximate Interval Between Onset and Death<br><b>2 days</b><br><b>2 days</b>  |  |   |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br><b>1</b> Yes <b>2</b> No<br><b>9</b> Unknown  |   |  |  |  |   |   |  |   |   | 23c. If yes, outcome of pregnancy<br><b>1</b> Live birth <b>2</b> Fetal death <b>3</b> Ectopic pregnancy<br><b>4</b> Pregnant at time of death <b>5</b> Other (specify)<br><b>9</b> Unknown |  | 23d. Date of delivery<br>Month Day Year |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |  |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown |   |   |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |   |   |  |   |   |   |  |   |  |  |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No           |   | 28d. Describe how injury occurred                                       |   |  |   |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |   |   |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |  |  |  |   |   |  |   |   | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>RES-000</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>January 27, 2008</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Kristen Nelson, MD 600 North Wolfe Street Baltimore Maryland 21287</b>  |   |  |  |  |   |   |  |   |   | 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b>   |  | 32. Registrar's Signature<br>           |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.


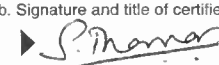

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02841

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>GRIGORIY ZEMLYANSKY</b>   |  | 2. Date of Death<br>Month Day Year<br><b>January 31, 2008</b>  |  | 3. Time of Death<br>M<br><b>7:45 A</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Greater Baltimore Medical Center</b>  |  | 4b. City, Town, or Location of Death<br><b>Towson</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| 5. Social Security Number<br><b>N/A</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>11/21/1928</b> | 9. Birthplace (State or Foreign Country)<br><b>UKRAINE</b>   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>BALTIMORE</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |
| 10e. Street and Number<br><b>2201 WOODBOX LANE</b>   |  | 10f. Zip Code<br><b>21209</b>  |  | 10g. Citizen of What Country?<br><b>UKRAINE</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:             |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College 4 (1-4or 5+) <input checked="" type="checkbox"/>   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MANAGER</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>SHMUEL ZEMLYANSKY</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CEILIA CHANA</b>   |  | 16b. Kind of Business/Industry<br><b>MANUFACTURING</b>   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>IRINA KRAVETS / DAUGHTER</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2201 WOODBOX LANE, BALTIMORE, MD 21209</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BALTIMORE HEBREW</b>  |  | 20c. Location - City or Town, State<br><b>02/01/2008 REISTERSTOWN, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>HEPATIC ENCEPHALOPATHY</b><br>Due to (or as a consequence of):<br>b. <b>CIRRHOSIS</b><br>Due to (or as a consequence of):<br>c. <b>HEPATITIS C</b><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>RENAL FAILURE</b>   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> 4 <input type="checkbox"/> Nursing Home <input type="checkbox"/> 5 <input type="checkbox"/> Residence <input type="checkbox"/> 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. Signature and title of certifier<br> MD  |  | 29c. License number<br><b>D0060687</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>01/31/2008</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SONY M THOMAS, MD, GBMC, 6701 N CHARLES ST, BALTIMORE, MD-21204</b>   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2008</b>  |  | 32. Registrar's Signature<br>   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For AMEND #24a/b per MD/29/08, BW, MCCO  
 State of Maryland / Department of Health and Mental Hygiene  
 AMEND #7,8, per INF1/23/08, BW, MCCO  
 Certificate of Death

Reg. No. 2008 02842

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permi. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Arthur Arlan</b>  |  | 2. Date of Death<br>Month <b>January</b> Day <b>15</b> Year <b>2008</b>   |  | 3. Time of Death<br><b>1102 M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Shady Grove Adventist Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| 5. Social Security Number<br><b>142 16 1322</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>April 22 1924</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>New Jersey</b>   |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Bethesda</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>8102 Hampden Lane</b>  |  | 10f. Zip Code<br><b>20814</b>  |  |
| 10g. Citizen of What Country?<br><b>USA</b>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>                                   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College</b>   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Manager</b>  |  | 16b. Kind of Business/Industry<br><b>Met Life Insurance Co</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>William Abraham</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillian Roth</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carol Arlan / Wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8102 Hampden Lane Bethesda, Maryland 20814</b>   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gdn of Remembrance</b>   |  | 20c. Location - City or Town, State<br><b>1/18/2008 Clarksburg, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><b>Hines Rinaldi Funeral Home</b><br><b>11800 New Hampshire Avenue Silver Spring, MD 20904</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Sepsis</b><br>Due to (or as a consequence of):<br>b. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>c. <b>Urine Infection</b><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)                                     |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Demonia</b>   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i> MD   |  | 29c. License number<br><b>MD0064235</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>January 15, 2008</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joel E. Bury, MD 9901 Medical Center Dr., Rockville, MD 20850</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 18 2008</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2008 02843

Physician/  
Medical Examiner

1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)  
James Phillip Anasiewicz

2. Date of Death  
Month Day Year  
January 22, 2008  
3. Time of Death  
1737 hrs

Funeral  
Director

4a. Facility Name (if not institution, give street and number)  
209 Meadow Gate Terrace

4b. City, Town, or Location of Death  
Gaithersburg

4c. County of Death  
Montgomery

5. Social Security Number  
284-50-8576

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)  
58 Yrs.

If Under 1 Year  
Months Days Hours Min.

8. Date of Birth (MM/DD/YYYY)  
August 11, 1949

9. Birthplace (State or Foreign Country)  
Ohio

Usual Residence of Decedent

10a. State  
Maryland

10b. County  
Montgomery

10c. City, Town or Location  
Gaithersburg

10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number  
209 Meadowgate Terrace

10f. Zip Code  
20877

10g. Citizen of What Country?  
United States

11. Marital Status  
1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.  
Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) College (1-4 or 5+) 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
Attorney

16b. Kind of Business/Industry  
Legal

17. Father's Name (First, Middle, Last)  
Leo Anasiewicz

18. Mother's Name (First, Middle, Maiden Surname)  
Stella Novak

19a. Informant's Name/Relationship (Type, Print)  
Leona Anasiewicz-Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
209 Meadowgate Terrace, Gaithersburg, MD 20877

20a. Method of Disposition  
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)  
Fort Lincoln Crematory

Date  
1-30-2008

20c. Location - City or Town, State  
Brentwood, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
Simple Tribute  
1040 Rockville Pike, Rockville, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. Sertraline, alprazolam, and alcohol intoxication  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

☒ UNPENDED

☐ AMENDED

#23a, 27, 28a-f, per ME, g876, 2/14/08 TT

IF FEMALE:  
23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?  
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death  
1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)  
Feb 1/22/2008

28b. Time of Injury  
End 5:30 pm

28c. Injury at Work?  
1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred  
subject ingested drugs and alcohol

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found; residence

28f. Location (Street and Number or Rural Route Number, City or Town, State)  
209 Meadow Gate Ter. Gaithersburg, MD

29a. Certifier (Check only one)  
1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier  
Ling Li, MD

29c. License number  
O.C.M.E.

29d. Date signed (Month, Day, Year)  
January 23, 2008

30. Name and address of person who completed cause of death (Item 23a)  
Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)  
JAN 30 2008

32. Registrar's Signature

11501  
Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical Examiner

Physician/  
Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02844

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Thelma E. Anderson

2. Date of Death  
Month Day Year

January 12 2008

3. Time of Death

2:05 M

4a. Facility Name (If not institution, give street and number)

Millennium @ South River

4b. City, Town, or Location of Death

Edgewater

4c. County of Death

Anne Arundel

5. Social Security Number

217-12-1795

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

8. Date of Birth (Month, Day, Year)

Aug. 6 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Harwood

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4650 Sands Road

10f. Zip Code

20776

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12thCollege (1-4or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Transportation

16b. Kind of Business/Industry

South County  
Health Center

17. Father's Name (First, Middle, Last)

John F. Chapman

18. Mother's Name (First, Middle, Maiden Surname)

Helen L. Hill

19a. Informant's Name/Relationship (Type, Print)

Helen E. Anderson (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4650 Sands Rd. Harwood, Md. 20776

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moses Cemetery

Date

1/19/08

20c. Location - City or Town, State

Drury, Md.

21. Signature of Funeral Service Licensee

Gary H. Reese M20883

22. Name and Address of Facility

Wm. Reese & Sons Mortuary, P.A.  
821 West St. Annapolis, Md. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Cardiac Arrhythmia

Due to (or as a consequence of):

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Old Cerebrovascular Disease  
Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Aditya Chopra

29c. License number

D57028

29d. Date signed (Month, Day, Year)

01-15-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aditya Chopra M.D. 600 Bridgely Ave. #231 Annapolis, MD 21401

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

Karen B. Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02845

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Chester Arthur Briggs

2. Date of Death

January 15, 2008

3. Time of Death

7:20 A<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Ginger Cove Health Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

305-42-7536

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

94

8. Date of Birth (Month, Day, Year)

May 29, 1913

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

4238 River Crescent Drive

10f. Zip Code

21401

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1931-1958

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Captain

16b. Kind of Business/Industry

U.S. Navy

17. Father's Name (First, Middle, Last)

Chester Calvin Briggs

18. Mother's Name (First, Middle, Maiden Surname)

Laura Karst

19a. Informant's Name/Relationship (Type, Print)

Laurie Candalar/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8227 Running Creek Ct. Springfield, VA 22153

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

1/17/2008

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Todd E. Liller

22. Name and Address of Facility

John M. Taylor Funeral Home  
147 Duke of Gloucester St., Annapolis, MD 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 days

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular disease  
Hypertension, malignant  
Dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an

autopsy  
performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending  
investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Paul Berey MD

29c. License number

D 0029571

29d. Date signed (Month, Day, Year)

01/15/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul B. Berey, MD 2225 E Defense Hwy, Crofton, MD 21114

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

Karan B. Spivey

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02846

Physician/  
Medical Examiner1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

William Clayton Bradley

2. Date of Death  
Month Day Year  
January 26, 20083. Time of Death  
1128 hrs4a. Facility Name (if not institution, give street and number)  
300 Byrn Street4b. City, Town, or Location of Death  
Cambridge4c. County of Death  
DorchesterFuneral  
Director5. Social Security Number  
216-33-32196. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
16 Yrs.If Under 1 Year  
Months Days Hours Min.8. Date of Birth (MM/DD/YYYY)  
07/12/19919. Birthplace (State or Foreign Country)  
Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Dorchester10c. City, Town or Location  
Hurlock10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number

405 Collins Avenue

10f. Zip Code

21643

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No specify:14. Race - American Indian, Black, White, etc.  
Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done  
during most of working life. DO NOT use retired)

Student

16b. Kind of Business/Industry

High School

17. Father's Name (First, Middle, Last)

Don William Bradley

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte Lankford

19a. Informant's Name/Relationship (Type, Print)

Don W. Bradley/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P. O. Box K, Hurlock, Maryland 21643

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other Specify:20b. Place of Disposition (Name of cemetery,  
cemetery or other place)

Unity Washington Cem.

Date

1/30/2008

20c. Location - City or Town, State

Hurlock, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Zeller Funeral Home, P. O. Box 207,  
East New Market, MD 21631

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Narcotic intoxication  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED☐ AMENDED

#23a, PII, 27, 28a-f, per ME, G877 3/10/08 TT

Approximate Interval  
Between Onset and  
Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions

contributing to death but not resulting in the underlying cause given in Part I.

Asthma

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☒ Yes 2 ☐ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☒ Could not be determined

28a. Date of Injury (Month, Day, Year)

Fnd 1/26/2008

28b. Time of Injury

Fnd 10:10 am

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

unk

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) house

28f. Location (Street and Number or Rural Route Number, City or Town, State)

300 Byrn Street Cambridge, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Margarita Korell

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 27, 2008

30. Name and address of person who completed cause of death (Item 23a)

Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

JAN 30 2008

32. Registrar's Signature

[Signature]

State  
RegistrarBaltimore, MD 21215-0036  
1550 Hollis  
Department of Health and Mental Hygiene  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02847

1- For State Registrar

|   |   |  |  |  |  |  |   |  |
|---|---|--|--|--|--|--|---|--|
| Physician / Medical Examiner                  | 1. Decedent's Name (First, Middle, Last)<br><b>Julian Kenneth Blake</b>   |  |  |  | 2. Date of Death<br>Month <b>01</b> Day <b>17</b> Year <b>2008</b>   |  | 3. Time of Death<br><b>14:13 P<sup>M</sup></b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Peninsula Regional Medical Center Salisbury MD</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Salisbury MD</b>  |  | 4c. County of Death<br><b>Wicomico</b>  |  |
| Funeral Director                              | 5. Social Security Number<br><b>220-52-0524</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct 13, 1949</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Wicomico</b>   |  | 10c. City, Town or Location<br><b>Salisbury</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>749 S. Division Street Apt. A</b>   |  | 10f. Zip Code<br><b>21804</b>   |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No          |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Roller Operator</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Paving Contractor</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>James Henry Mathews</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Cleo Blake</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Judith Blake</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>440 Oakley Street Cambridge, Maryland 21613</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bethel Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Cambridge, Maryland</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Janelle C. Henry</b>  |  |  |  | 22. Name and Address of Facility<br><b>HENRY FUNERAL HOME, P.A.<br/>510 Washington St. Cambridge, MD. 21613</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>pneumonia</b>   |  |  |  | Approximate Interval Between Onset and Death<br><b>unknown</b>   |  |   |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>ASCVD</b>  |  |  |  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)  |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |   |  |
|   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day Year)   |  |  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                 |  |
|   | 28d. Describe how injury occurred   |  |  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |
|   | 29b. Signature and title of certifier<br><b>Charles B. Silva Jr.</b>  |  |  |  | 29c. License number<br><b>D30853</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>1/18/08</b>   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Charles B. Silva Jr. Peninsula Regional Medical Center Salisbury MD 21801</b>  |  |  |  | 31. Date filed (Month, Day, Year)<br><b>JAN 22 2008</b>  |  |   |  |
|   | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |  |  |   |  |

1- For State Registrar

1. Decedent's Name (First, Middle, Last)

Dustin Elliott Bruch

2. Date of Death

January 4, 2007 2008

3. Time of Death

2239 hrs

4a. Facility Name (if not institution, give street and number)

Penninsula Regional Medical Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

215-31-2148

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

17

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth (MM/DD/YYYY)

12/12/1990

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Delmar

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8955 Bi-State Blvd.

10f. Zip Code

21875

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

student

16b. Kind of Business/Industry

education

17. Father's Name (First, Middle, Last)

Robert L. Bruch

18. Mother's Name (First, Middle, Maiden Surname)

Kay Elliott

19a. Informant's Name/Relationship (Type, Print)

Kay Elliott/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8955 Bi-State Blvd., Delmar, MD 21875

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place)

Powellville Cemetery

Date

1/11/08

20c. Location - City or Town, State

Powellville, MD

21. Signature of Funeral Service Licensee

*W. Robinson CFSE*

22. Name and Address of Facility

Holloway Funeral Home Professional Association  
501 Snow Hill Rd., Salisbury, MD 21804

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED

☒ AMENDED #2, per ME, 6875, 1/24/08 TT / 28a, per ME, 6877 3/12/08 TT

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

Jan 4, 2007 2008

28b. Time of Injury

2140 hrs

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Driver auto auto collision

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) Local Street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Dagsboro Road and Parsonsburg Road, Salisbury, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Margarita Korell*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 6, 2008

30. Name and address of person who completed cause of death (Item 23a)

Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

OCME

State Registrar

31. Date filed (Month, Day, Year)

JAN 8 2008

32. Registrar's Signature

*Dustin Elliott Bruch*



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Register AMEND #23a, Pt. 2, per MD, 1/18/08, DPH, MCO Certificate of Death

Reg. No.

2008 02849

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LAWRENCE WILLARD CALLEN, JR.

2. Date of Death

Month Day Year  
JANUARY 12, 2008

3. Time of Death

9:12 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

434-36-5257

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
APRIL 3, 1927

9. Birthplace (State or Foreign Country)

LOUISIANA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1117 TIFFANY ROAD

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces? ☒ Yes ☐ No  
If Yes, Give Year or Dates: WWII AND KOREAN13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

AUTHOR

16b. Kind of Business/Industry

DEPARTMENT OF LABOR

17. Father's Name (First, Middle, Last)

LAWRENCE WILLARD CALLEN, SR.

18. Mother's Name (First, Middle, Maiden Surname)

EMILY A. BARROUQUERE

19a. Informant's Name/Relationship (Type, Print)

HOLLY C. BERARDI - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

228 THISTLE DRIVE, SILVER SPRING, MD 20901

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

PARKLAWN MEMORIAL PARK

Date

JANUARY 19, 2008 ROCKVILLE, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC.

11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Sepsis

b. Due to (or as a consequence of):

Hypertension

c. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)

9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alcohol Abuse Alcoholism

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an  
autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

H0064588

29d. Date signed (Month, Day, Year)

1-14-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASHISH KISHORE TOLIA, M.D., 1500 FOREST GLEN ROAD, SILVER SPRING, MD 20910

31. Date filed (Month, Day, Year)

JAN 18 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02850

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Peter Marios Cavas

2. Date of Death

Month Day Year  
January 12, 2008

3. Time of Death

3:30P M

4a. Facility Name (If not institution, give street and number)

802 Coxswain Way Apt. 210

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

036-18-6451

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 3, 1925

9. Birthplace (State or Foreign Country)

Rhode Island

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

802 Coxswain Way

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No WWII  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Economist

16b. Kind of Business/Industry

Federal Governemt

17. Father's Name (First, Middle, Last)

Thomas Arthur Cavas

18. Mother's Name (First, Middle, Maiden Surname)

Georgia Vergos

19a. Informant's Name/Relationship (Type, Print)

Barbara L. Cavas/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

802 Coxswain Way Annapolis, Md. 21401 Apt. 210

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Maryland Veterans Cem.

Date

1/16/2008

20c. Location - City or Town, State

Crownsville, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home  
2973 Solomons Island Rd. Edgewater, Md. 21037

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. GLIOBLASTOMA MULTIFORME

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
1 YEAR

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D16364

29d. Date signed (Month, Day, Year)

11/4/08

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

PETER GRATE MD 300 HANNA RD MD 21401

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2008 02851

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last)

Charles Monroe Camper, SR.

2. Date of Death

Jan. 18, 2008

3. Time of Death

7:40p<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Chesapeake Woods Center

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

212-16-7275

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr. 1 29/1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Hurlock

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

116 Gold Rush Lane P.O. Box 618

10f. Zip Code

21643

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1942  
1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Processing Line Worker

16b. Kind of Business/Industry

Food Cannery

17. Father's Name (First, Middle, Last)

Charles E. Camper

18. Mother's Name (First, Middle, Maiden Surname)

Georgia Young

19a. Informant's Name/Relationship (Type, Print)

Glanceice Camper

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

116 Gold Rush Lane P.O. Box 618 Hurlock, MD. 21643

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Thompson Cemetery

Date

1/24/08

20c. Location - City or Town, State

Thompstontown, MD

21. Signature of Funeral Service Licensee

Janelle C. Henry

22. Name and Address of Facility

Henry Funeral Home, P.A.  
510 Washington St. Cambridge, MD. 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

year

year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William H. Robins, M.D.

29c. License number

028348

29d. Date signed (Month, Day, Year)

1/24/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William H. Robins, M.D., 200 Civic Avenue, Salisbury, MD 21804

31. Date filed (Month, Day, Year)

JAN 23 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 02852

Physician/  
Medical Examiner

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. For State Registrar   |  | 2. Date of Death<br>Month Day Year<br>January 22, 2008  |  | 3. Time of Death<br>2026 hrs  |  |
| 1. Decedent's Name (First, Middle, Last)<br>SOLOMON RUSSELL DIXON  |  |   |  |   |  |
| 4a. Facility Name (if not institution, give street and number)<br>Shady Grove Hospital   |  | 4b. City, Town, or Location of Death<br>Rockville   |  | 4c. County of Death<br>Montgomery   |  |
| 5. Social Security Number<br>214-79-1626   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>Yrs. 7  |  |
| 8. Date of Birth (MM/DD/YYYY)<br>June 12, 2007   |  | 9. Birthplace (State or Foreign Country)<br>MD  |  |   |  |
| Usual Residence of Decedent  |  |   |  |   |  |
| 10a. State<br>MD   |  | 10b. County<br>Montgomery   |  | 10c. City, Town or Location<br>Gaithersburg   |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |
| 10e. Street and Number<br>1184 Southern Night Lane   |  | 10f. Zip Code<br>20879  |  | 10g. Citizen of What Country?<br>U.S.A.   |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |  |   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) N/A<br>College (1-4 or 5+) N/A  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>N/A  |  | 16b. Kind of Business/Industry<br>N/A   |  |
| 17. Father's Name (First, Middle, Last)<br>Wayne Dixon, Jr   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Maketa Patterson   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Maketa Dixon (Mother)  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1184 Southern Night Ln, Gaithersburg, MD 20879   |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Parklawn Mem Park   |  | 20c. Location - City or Town, State<br>Rockville, MD  |  |
| 21. Signature of Funeral Service Licensee<br>George R. Snowden, per DVR  |  | 22. Name and Address of Facility<br>SNOWDEN FUNERAL HOME, P.A.<br>246 N. Washington St, Rockville, MD 20850   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) a. Sudden Infant Death Syndrome (SIDS)<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><input checked="" type="checkbox"/> UNPENDED <input checked="" type="checkbox"/> AMENDED<br>#21, per FD, g877 3/11/08 TT 23a, 27 per me g877 3-21-08 vt |  |   |  |   |  |
| 23b. If FEMALE: Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:       |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |
| 29b. Signature and title of certifier<br>Ana Rubio   |  | 29c. License number<br>O.C.M.E.   |  | 29d. Date signed (Month, Day, Year)<br>January 23, 2008   |  |
| 30. Name and address of person who completed cause of death (Item 23a)<br>Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br>JAN 30 2008   |  | 32. Registrar's Signature<br>Beverly B. Sparks  |  |   |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical Examiner

Division of Vital Records, P.O. Box 68760,  
Baltimore, MD 21268-0760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
 1- For State Registrar Amend Item 24a per dr., g876, 02/16/08  
 Certificate of Death  
 Reg. No. 2008 02853

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

|   |   |   |   |   |  |  |  |   |   |
|---|---|---|---|---|--|--|--|---|---|
| Physician /Medical Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Nancy Virginia DeStefano  |   |   | 2. Date of Death<br>Month Day Year<br>January 09 2008   |  |  | 3. Time of Death<br>1:00 P <sup>M</sup>                          |   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br>503 Captain John Brice Way  |   |   | 4b. City, Town, or Location of Death<br>Annapolis   |  |  | 4c. County of Death<br>Anne Arundel                              |   |   |
| Funeral Director  | 5. Social Security Number<br>220-48-3298  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>75 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>06/28/1932   | 9. Birthplace (State or Foreign Country)<br>Washington, D.C.   |  |  |   |   |
|   | Usual Residence of Decedent   |   |   |   |  |  |  |   |   |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  | 10b. County<br>Anne Arundel   | 10c. City, Town or Location<br>Annapolis  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |   |
|   | 10e. Street and Number<br>503 Captain John Brice Way  |   |   | 10f. Zip Code<br>21401  |  | 10g. Citizen of What Country?<br>United States   |  |   |   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |   |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+) 2   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |   | 16b. Kind of Business/Industry<br>Home   |  |  |   |   |
|   | 17. Father's Name (First, Middle, Last)<br>William Earl Harrison  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Dorothy Jones  |  |  |  |   |   |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Gina M. DeStefano/Daughter  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>820 Northfield Lane, Crownsville, Maryland 21032 |  |  |  |   |   |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery   |   | Date<br>01/14/08   |  | 20c. Location - City or Town, State<br>Suitland, Maryland        |   |   |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |   | 22. Name and Address of Facility<br>George P. Kalas Funeral Home<br>2973 Solomons Island Rd., Edgewater, MD 21037                                 |  |  |  |   |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>myelofibrosis</i><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |  |  |  |   | Approximate Interval Between Onset and Death<br>3 yrs |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |  |  |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |  |  |  |   |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  | 28d. Describe how injury occurred   |   |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |  |  |   |   |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |   |  |  |  |   |   |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |   |   | 29c. License number<br>D0018529 MD  |   |  | 29d. Date signed (Month, Day, Year)<br>01-09-2008  |  |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>2009 TIDEWATER COLONY DR, ANNAPOLIS, MD 21401 Jon B. Lowe   |   |   |   |   |  |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br>JAN 16 2008  |   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |  |   |   |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02854

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |   |  |  |  |  |   |  |
|--|--|---|---|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Robert Eldon Dietsch</b>  |  |   | 2. Date of Death<br>Month <b>January</b> Day <b>17</b> Year <b>2008</b>   |  |  | 3. Time of Death<br><b>12:40 A<sup>M</sup></b>   |  |   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Frederick</b>  |  |  | 4c. County of Death<br><b>Frederick</b>  |  |   |  |
| 5. Social Security Number<br><b>287-12-3947</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>July 31, 1922</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b> |  |
| Usual Residence of Decedent  |  |   |   |  |  |  |  |   |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Frederick</b>   |   | 10c. City, Town or Location<br><b>Mt. Airy</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>5811 Catoctin Overlook Drive</b>  |  |   | 10f. Zip Code<br><b>21771</b>   |  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b>   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Systems Analyst</b> |  |  | 16b. Kind of Business/Industry<br><b>IMB</b>   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Albert Dietsch</b>   |  |   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Frances Rau</b>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>David Dietsch/ Son</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5811 Catoctin Overlook Drive, Mt. Airy, MD 21771</b>                                     |  |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Stauffer Crematory Inc.</b>                            |  |  | 20c. Location - City or Town, State<br><b>Frederick, Maryland</b>  |  |   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   | 22. Name and Address of Facility<br><b>Stauffer Funeral Home P. A.<br/>1621 Opossumtown Pike, Frederick, Maryland 21702</b>         |  |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Sepsis</b><br>Due to (or as a consequence of):<br><b>b. Acute Myocardial Infarction</b><br>Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |  |   |   |  |  |  |  | Approximate Interval Between Onset and Death            |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br>9 Unknown                        |   |  |  |  | 23d. Date of delivery<br>Month Day Year  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>End stage Renal disease</b><br><b>Coronary artery disease</b>   |  |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                       |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D0060417</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>1-17-08</b>  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Hemen Shah, 650 Thomas Johnson Dr, Frederick MD 21702</b>   |  |   |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 22 2008</b>  |  |   | 32. Registrar's Signature<br>   |  |  |  |  |   |  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02855

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Newton Duncan

2. Date of Death

Month Day Year  
January 16, 2008

3. Time of Death

5:30 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

103 E. Main Street Apt. A

4b. City, Town, or Location of Death

Thurmont

4c. County of Death

Frederick

5. Social Security Number

030-20-3689

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

May 27, 1929

9. Birthplace (State or Foreign  
Country)

Massachusetts

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Thurmont

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

103 E. Main Street Apt. A

10f. Zip Code

21788

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1951-5313. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Press Dept. Supervisor

16b. Kind of Business/Industry

Tool &amp; Die Company

17. Father's Name (First, Middle, Last)

James Duncan

18. Mother's Name (First, Middle, Maiden Surname)

Alice Newton

19a. Informant's Name/Relationship (Type, Print)

Doris A. Duncan/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 E. Main Street Apt. A Thurmont, MD 21788

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Crematory

Date

01/18/08

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Beverly L. Heckrotte

22. Name and Address of Facility

Going Home Cremation Service P.O. Box 784

MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.a. Carcinoma of Lung - metastatic  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

3-4 mos.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify) N/A23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Brad J. Cooper MD

29c. License number

D22819

29d. Date signed (Month, Day, Year)

1/17/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRAD J. COOPER, M.D., 52 WATER ST., THURMONT, MD. 21788

31. Date filed (Month, Day, Year)

JAN 18 2008

32. Registrar's Signature

Beverly L. Heckrotte

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
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once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02856

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CLAIRE EISNER

2. Date of Death

Month Day Year  
JANUARY 15, 2008

3. Time of Death

1:00 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESA

4c. County of Death

MONTGOMERY

5. Social Security Number

053-03-3110

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

04/10/1913

9. Birthplace (State or Foreign Country)

POLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

BETHESDA

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6530 DEMOCRACY BLVD

10f. Zip Code

20817

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

CASHIER

16b. Kind of Business/Industry

RETAIL

17. Father's Name (First, Middle, Last)

SAMUEL WAPNER

18. Mother's Name (First, Middle, Maiden Surname)

DORA SEIDEL

19a. Informant's Name/Relationship (Type, Print)

PHYLLIS SLAVIN/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4401 HORNBEAM DRIVE, ROCKVILLE, MARYLAND 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

BETH ISRAEL CEMETERY

Date

01/17/2008

20c. Location - City or Town, State

WOODBIDGE, NEW JERSEY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. GASTROINTESTINAL BLEED

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)

29b. Signature and title of certifier

29c. License number

D62949

29d. Date signed (Month, Day, Year)

JANUARY 15, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. NATASHA PRITINA HAAG, 8600 OLD GEORGETOWN ROAD, BETHESDA, MARYLAND 20814

31. Date filed (Month, Day, Year)

JAN 18 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02857

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Fred Grabowsky

2. Date of Death

January 15, 2008

3. Time of Death

7:10 P<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

152-16-9705

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 8, 1926

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

475 Maple Road

10f. Zip Code

21146

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates: 1949-6913. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Lawyer

16b. Kind of Business/Industry

Law

17. Father's Name (First, Middle, Last)

Kosrel Grabowsky

18. Mother's Name (First, Middle, Maiden Surname)

Devorta Fajnkuchen

19a. Informant's Name/Relationship (Type, Print)

Laila Grabowsky/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

475 Maple Road Severna Park, Maryland 21146

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Baltimore Crematory

Date

1/17/2008

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Todd E. Miller

22. Name and Address of Facility

John M. Taylor Funeral Home

147 Duke of Gloucester St., Annapolis, MD 21401

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Pneumonia  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

&gt; 1 week

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?☐ Yes ☐ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute renal failure Prostate cancer

Septicemia

Cardiomyopathy

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an  
autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert Peterson MD

29c. License number

D 24804

29d. Date signed (Month, Day, Year)

1-15-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Peterson MD

AAMC Annapolis MD 21401

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

Kean B. Smith

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02858

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Scheller Leon Garlock

2. Date of Death

January 20 2008

3. Time of Death

3:53 P M

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

214-14-9872

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
DEC. 4, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4916 Old Swimming Pool Rd.

10f. Zip Code

21703

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Major / officer

16b. Kind of Business/Industry

U.S. Army/Military

17. Father's Name (First, Middle, Last)

Scheller L. Garlock

18. Mother's Name (First, Middle, Maiden Surname)

Roberta ( Unknown )

19a. Informant's Name/Relationship (Type, Print)

Geraldine S. Garlock / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4916 Old Swimming Pool Rd./ Frederick, MD 21703

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Stauffer Crematory

Date

JAN. 22, 2008

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

Marianne H. Stauffer

22. Name and Address of Facility Stauffer Funeral Home

1621 Opossumtown Pike, / Frederick, MD 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. pneumonia

Due to (or as a consequence of):

b. acute renal failure

Due to (or as a consequence of):

c. bacteremia

Due to (or as a consequence of):

d. stage four Lung Cancer

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Myung Hee Nam

29c. License number

D0035106

29d. Date signed (Month, Day, Year)

1/21/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Myung Hee Nam / 400 West 7th St./ Frederick, Maryland 21701

31. Date filed (Month, Day, Year)

JAN 22 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10-11A

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 02859

1- For State Registrar

Physician /Medical Examiner

Funeral Director

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>HANNAH DRYDEN GOODWIN</b>                             |  | 2. Date of Death<br>Month <b>01</b> Day <b>18</b> Year <b>08</b> |  | 3. Time of Death<br><b>6:21A M</b>                          |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Coastal Hospice at the Lake</b> |  | 4b. City, Town, or Location of Death<br><b>Salisbury</b>         |  | 4c. County of Death<br><b>Wicomico</b>                      |  |
| 5. Social Security Number<br><b>215-62-1172</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>55</b> Yrs.                 | 8. Date of Birth (Month, Day, Year)<br><b>12/23/1952</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |

|                         |  |                                |  |   |  |  |  |
|-------------------------|--|--------------------------------|--|---|--|--|--|
| 10a. State<br><b>MD</b> |  | 10b. County<br><b>Wicomico</b> |  | 10c. City, Town or Location<br><b>Salisbury</b> |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|-------------------------|--|--------------------------------|--|---|--|--|--|

|  |  |                               |  |   |  |
|--|--|-------------------------------|--|---|--|
| 10e. Street and Number<br><b>31854 Quail Ridge Drive</b> |  | 10f. Zip Code<br><b>21804</b> |  | 10g. Citizen of What Country?<br><b>USA</b> |  |
|--|--|-------------------------------|--|---|--|

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|--|--|---|--|--|--|---|--|

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Management</b> |  | 16b. Kind of Business/Industry<br><b>Mental Health</b> |  |
|---|--|--|--|--|--|

|   |  |  |  |
|---|--|--|--|
| 17. Father's Name (First, Middle, Last)<br><b>George Francis Dryden</b> |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Hall</b> |  |
|---|--|--|--|

|  |  |  |  |
|--|--|--|--|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ronald L. Goodwin (husband)</b> |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>31854 Quail Ridge Dr., Salisbury, MD 21804</b> |  |
|--|--|--|--|

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rehoboth Presbyterian Cem.</b> |  | 20c. Location - City or Town, State<br><b>1/22/2008 Rehoboth, MD</b> |  |
|---|--|---|--|--|--|

|  |  |   |  |
|--|--|---|--|
| 21. Signature of Funeral Service Licensee<br><b>Michael A Dean</b> |  | 22. Name and Address of Facility<br><b>Holloway Funeral Home, Professional Association<br/>103 Linden Ave., Pocomoke City, MD 21851</b> |  |
|--|--|---|--|

|   |  |  |  |
|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>CARCINOMA OF LUNGS</b> |  | Approximate Interval Between Onset and Death |  |
| Due to (or as a consequence of):  |  |  |  |
| Due to (or as a consequence of):  |  |  |  |
| Due to (or as a consequence of):  |  |  |  |
| Due to (or as a consequence of):  |  |  |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year |  |
|--|--|---|--|---|--|

|  |  |  |  |
|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|--|--|--|--|

|   |  |  |  |
|---|--|--|--|
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|---|--|--|--|

|   |  |   |  |
|---|--|---|--|
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
|---|--|---|--|

|   |  |  |  |                                 |  |  |  |                                   |  |
|---|--|--|--|---------------------------------|--|--|--|-----------------------------------|--|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b> |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred |  |
|   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) |  |                                 |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |                                   |  |

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>[Signature]</b> |  | 29c. License number<br><b>00058410</b> |  | 29d. Date signed (Month, Day, Year)<br><b>1-18-08</b> |  |
|--|--|---|--|--|--|---|--|

|  |  |
|--|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GHUMAN WARIO COASTAL HOSPICE P.O. Box 1733 Salisbury MD 21802</b> |  |
|--|--|

|   |  |   |  |
|---|--|---|--|
| 31. Date filed (Month, Day, Year)<br><b>JAN 22 2008</b> |  | 32. Registrar's Signature<br><b>[Signature]</b> |  |
|---|--|---|--|

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02860

1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Paul Raymond Holbrook, Jr.

2. Date of Death

Month Day Year  
January 12, 2008

3. Time of Death

0940 hrs

4a. Facility Name (if not institution, give street and number)

Annapolis Yacht Club

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

280-42-2692

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

60

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

Jan 23, 1947

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Ohio

10b. County

Franklin

10c. City, Town or Location

Columbus

10d. Inside City Limits

1 Yes 2 X No

10e. Street and Number

1342 Old Henderson

10f. Zip Code

43220

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 XX Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No

If Yes, Give Year or Dates: 67 - 73

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 X No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Pilot

16b. Kind of Business/Industry

Ohio National Guard

17. Father's Name (First, Middle, Last)

Paul R. Holbrook, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary L. Clark

19a. Informant's Name/Relationship (Type, Print)

Nicholas Holbrook / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6365 Saddle Lane W., Westerville, Ohio 43081

20a. Method of Disposition

1 Burial 2 XX Cremation 3 Removal from State

4 Donation 5 Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Crematory

Date

1/18/08

1/18/07

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

*Nicholas G. Kutta*

22. Name and Address of Facility

John M. Taylor Funeral Home

147 Duke of Gloucester St., Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ~~Drowning~~ Drowning and hypothermia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

UNPENDED

X AMENDED 23a, per ME 8876, 2/15/08 TT #205 per MD AACO Health Dept. 1/17/08 sb

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (Specify)

9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Arteriosclerotic Cardiovascular Disease

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed?

1 X Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 No

25. Was case referred to medical examiner?

1 X Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 X Other: Scene

27. Manner of Death

1 Natural 5 Pending Investigation  
2 X Accident  
3 Suicide 6 Could not be determined  
4 Homicide

28a. Date of Injury (Month, Day, Year)

FOUND: Jan 12, 2008

28b. Time of Injury

FOUND: 0900 hrs

28c. Injury at Work?

1 Yes 2 X No

28d. Describe how injury occurred

Subject drowned in creek

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) Creek

28f. Location (Street and Number or Rural Route Number, City or Town, State)  
Annapolis Yacht Club, Annapolis, MD

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Laron Locke*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 13, 2008

30. Name and address of person who completed cause of death (Item 23a)

Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

*Paul R. Holbrook, Jr.*Physician/  
Medical Examiner  
  
Funeral  
Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02861

Physician/  
Medical ExaminerFuneral  
Director1- For State  
Registrar

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Monteray Arkell Hastey Sr</b>  |  | 2. Date of Death<br>Month Day Year<br><b>January 4, 2008</b>  |  | 3. Time of Death<br><b>1214 hrs</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Anne Arundel Medical Center</b>  |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>  |  | 4c. County of Death<br><b>Anne Arundel</b>  |  |
| 5. Social Security Number<br><b>220-84-7332</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>37 Yrs.</b>  | 8. Date of Birth (MM/DD/YYYY)<br><b>Aug 5 1970</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
| Usual Residence of Decedent   |  | 10c. City, Town or Location   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Anne Arundel</b>   | 10e. Street and Number<br><b>19 Washington Dr.</b>  |  | 10f. Zip Code<br><b>21401</b>   | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Maintenance Man</b>   |  | 16b. Kind of Business/Industry<br><b>Harbour Gates Apartment &amp; Condo's</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Sidney Hastey</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pamela Gross</b>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Yvette Hastey (Wife)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21401</b><br><b>1150 Madison St. Apt B1 Annapolis, Md.</b>   |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Memorial Park</b>  |  | 20c. Location - City or Town, State<br><b>1-16-08 Annapolis, Md.</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>Ferry H. Reese</i>  |  | 22. Name and Address of Facility<br><b>Wm. Reese &amp; Sons Mortuary, P.A.</b><br><b>821 West St. Annapolis, Md. 21401</b>  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) a. <b>Hanging</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED |  |   |  |   | Approximate Interval Between Onset and Death   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>g <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:          |  |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br><b>FOUND: Jan 4, 2008</b>   | 28b. Time of Injury<br><b>FOUND: 1125 hrs</b>      | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Jail</b>  |  | 28d. Describe how injury occurred<br><b>Subject hanged self</b>   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><i>Patricia Aronica-Pollak</i>   |  | 29c. License number<br><b>O.C.M.E.</b>  | 29d. Date signed (Month, Day, Year)<br><b>January 5, 2008</b>  |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 16 2008</b>   |  | 32. Registrar's Signature<br><i>Patricia Aronica-Pollak</i>   |  |   |  |

Baltimore, MD 21215-0036

Department of Health and Mental Hygiene

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02862

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Harold Houston Hawfield</b>  |  | 2. Date of Death<br>Month <b>January</b> Day <b>14</b> Year <b>2008</b>  |  | 3. Time of Death<br><b>10:30A</b> M  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>2827 Fennel Road</b>   |  | 4b. City, Town, or Location of Death<br><b>Edgewater</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| 5. Social Security Number<br><b>246-05-1102</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>May 6, 1921</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>                                  |
| Usual Residence of Decedent   |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Anne Arundel</b>   | 10c. City, Town or Location<br><b>Edgewater</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>2827 Fennel Road</b>   |  | 10f. Zip Code<br><b>21037</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII</b><br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>5+</b>   |  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Physician</b>   |  | 16b. Kind of Business/Industry<br><b>Health Care</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Samuel Glen Hawfield</b>  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Kate Clark</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Isolde M. Hawfield/Wife</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2827 Fennel Rd. Edgewater, MD. 21037</b> |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Kalas Crematory</b>   |  | 20c. Location - City or Town, State<br><b>1/16/2008 Edgewater, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>George P. Kalas Funeral Home</b><br><b>2973 Solomons Island Rd. Edgewater, MD. 21037</b>  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>a. Dehydration</b><br>Due to (or as a consequence of):<br><b>b. Alzheimer's Dementia</b><br>Due to (or as a consequence of):<br><b>c. Anorexia</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |  |  |  | Approximate Interval Between Onset and Death<br><b>~1 wk</b><br><b>~10 yrs</b><br><b>~2 months</b> |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown            |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><br><b>Nancy D Rivera-King, M.D.</b>  |  | 29c. License number<br><b>D0040904</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>January 15 2008</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Nancy D Rivera-King, M.D. 1209A Marda Lane, Annapolis, MD 21403</b>  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 16 2008</b>   |  | 32. Registrar's Signature<br>   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02863

1- For State  
RegistrarPhysician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Henry P. Hutton Jr

2. Date of Death

Month Day Year  
January 11, 2008

3. Time of Death

2251 hrs

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

413 North Port Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

214-40-2575

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

May 15 1942

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

413 North Port St.

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year 1975-81

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

1 1/2 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Driver

16b. Kind of Business/Industry

Gunther

Trucking Company

17. Father's Name (First, Middle, Last)

Henry P. Hutton Sr

18. Mother's Name (First, Middle, Maiden Surname)

Helen Davis

19a. Informant's Name/Relationship (Type, Print)

Diane Hutton (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

413 North Port St. Baltimore, Md. 21224

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

1-18-08

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Jenny H. Reese MD 0483

Name and Address of Facility

821 West St. Annapolis, Md. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)6 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus, prostate cancer, chronic alcohol abuse

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Melissa Brassell, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 12, 2008

30. Name and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

Jenny H. Reese MD 0483

Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitTo Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02864

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Teresa Jane Hoke

2. Date of Death  
Month Day Year  
January 17, 20083. Time of Death  
6:30 PMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Homewood At Crumland Farms

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

215-14-1726

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

November 16, 1913 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7407 Willow Road

10f. Zip Code

21702

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Hilleary Jamison

18. Mother's Name (First, Middle, Maiden Surname)

Cora Gertrude Best

19a. Informant's Name/Relationship (Type, Print)

Margaret L. Krow (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4506 NW Wandering Oak Ct. Jensen Beach, FL 34957

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

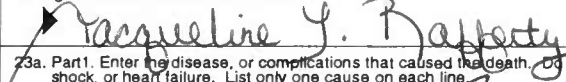
20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery Jan. 22, 2008 Frederick, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Stauffer Funeral Homes PA  
1621 Opossumtown Pike Frederick, MD 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. \_\_\_\_\_  
Due to (or as a consequence of):c. \_\_\_\_\_  
Due to (or as a consequence of):

d. \_\_\_\_\_

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease  
Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D30496

29d. Date signed (Month, Day, Year)

1/18/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Francis E. Becker MD, 300 W. 9th St, Frederick, MD 21701

31. Date filed (Month, Day, Year)

JAN 22 2008

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.


State of Maryland / Department of Health and Mental Hygiene

2008 02865

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |  |  |  |   |   |                                   |   |  |  |                                   |  |
|--|---|--|---|--|--|--|--|--|--|---|---|-----------------------------------|---|--|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Rev. Robert P. Hanlon, O.S.F.S.   |  |   |  |  |  | 2. Date of Death<br>Month Day Year<br>January 23 2008  |  |  | 3. Time of Death<br>1420 P M  |   |                                   |   |  |  |                                   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Annecy Hall   |  |   |  |  |  | 4b. City, Town, or Location of Death<br>Childs   |  |  | 4c. County of Death<br>Cecil  |   |                                   |   |  |  |                                   |  |
| Funeral<br>Director  | 5. Social Security Number<br>207-14-4071  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>84 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>SEPT 22, 1923   |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania |   |   |                                   |   |  |  |                                   |  |
|  | Usual Residence of Decedent   |  |   |  |  |  | 10a. State<br>Maryland   |  | 10b. County<br>Cecil                                     |   | 10c. City, Town or Location<br>Childs   |                                   |   |  |  |                                   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  | 10e. Street and Number<br>1120 Blue Ball Road  |  | 10f. Zip Code<br>21916                                   |   | 10g. Citizen of What Country?<br>United States  |                                   |   |  |  |                                   |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:<br>World War II |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |   |   |                                   |   |  |  |                                   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 5+ College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Priest/Educator   |  |  |  | 16b. Kind of Business/Industry<br>Religious              |   |   |                                   |   |  |  |                                   |  |
|  | 17. Father's Name (First, Middle, Last)<br>William V. Hanlon  |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Margaret Tompkins   |  |  |   |   |                                   |   |  |  |                                   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Oblates of St. Francis de Sales   |  |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2200 Kentmere Parkway, Wilmington, DE 19806 |  |  |   |   |                                   |   |  |  |                                   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Oblate Cemetery   |  | Date<br>January 26, 2008   |  | 20c. Location - City or Town, State<br>Childs, MD  |  |  |   |   |                                   |   |  |  |                                   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |  |  |  | 22. Name and Address of Facility<br>Hicks Home for Funerals, P.A.<br>103 W. Stockton Street, Elkton, MD 21921                                |  |  |   |   |                                   |   |  |  |                                   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Chronic obstructive pulmonary disease<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |  |  |  |  |  |   | Approximate Interval Between Onset and Death<br>20 years  |                                   |   |  |  |                                   |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  |   |  |  |  |  |  |  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death<br>5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |                                   | 23d. Date of delivery<br>Month Day Year |  |  |                                   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |                                   |   |  |  |                                   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |  |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                                   |   |  |  |                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |  |  |  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                                   |   |  |  |                                   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation<br>6 <input type="checkbox"/> Could not be determined  |   |  |   |  |  |  |  |  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M          |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred |  |
| 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)   |   |  |   |  |  |  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                                   |   |  |  |                                   |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |  |  |  |  |  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br>C2-2005526 |   | 29d. Date signed (Month, Day, Year)<br>January 28, 2008                              |  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Christine E. K. Horak, DO, 42 Suburban Plaza Newark DE 19711   |   |  |   |  |  |  |  |  |  |   |   |                                   |   |  |  |                                   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 04 2008   |   |  |   |  |  |  |  |  |  | 32. Registrar's Signature<br>  |   |                                   |   |  |  |                                   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02866

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clara Belle Hoffman

2. Date of Death  
Month Day Year  
January 15, 20083. Time of Death  
6:30 PMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

College View Center

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

220-16-1006

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 5, 1918

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State  
MD

10b. County

Frederick

10c. City, Town or Location

Brunswick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1100 Peach Orchard Lane

10f. Zip Code

21716

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Franklin G. Norris

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Powers

19a. Informant's Name/Relationship (Type, Print)

Walter Smith (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8530 Edgewood Church Rd., Frederick, MD 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Locust Valley Cemetery

Date

1/18/2008

20c. Location - City or Town, State

Middletown, MD

21. Signature of Funeral Services Licensee

22. Name and Address of Facility

Donald B. Thompson Funeral Home  
P O Box 18, Middletown, MD 2176923a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Cardiomyopathy  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and DeathSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive Pulmonary disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury  
M28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0060417

29d. Date signed (Month, Day, Year)

1-15-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hemen Shah, 65 c Thomas Johnson Dr. Frederick MD 21702

31. Date filed (Month, Day, Year)

JAN 22 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 02867

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Jeanette Bradshaw Hughes

2. Date of Death

January 19 2008

3. Time of Death

1030 M

Funeral Director

4a. Facility Name (If not institution, give street and number)

Peninsula Regional Medical Center

4b. City, Town, or Location of Death

Salisbury, MD

4c. County of Death

Wicomico

5. Social Security Number

214-30-9383

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

8. Date of Birth (Month, Day, Year)

June 16, 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State MD

10b. County Dorchester

10c. City, Town or Location

Vienna

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4 Middle Street

10f. Zip Code

21869

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

secretary

16b. Kind of Business/Industry

legal

17. Father's Name (First, Middle, Last)

Everett Bradshaw Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Clara Vivian Phillips

19a. Informant's Name/Relationship (Type. Print)

Thomas P. Hughes son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Middle St., Vienna, MD 21869

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cem.

Date

1/25/08

20c. Location - City or Town, State

Hurlock, MD

21. Signature of Funeral Service Licensee

*B. K. R.*

22. Name and Address of Facility

Thomas Funeral Home P.A.  
700 Locust St., Cambridge, MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

unknown

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No

9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown

3 ☐ Ectopic pregnancy

5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient

2 ☒ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician

2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Charles B. Silva Jr M.D.*

29c. License number

D30853

29d. Date signed (Month, Day, Year)

1/21/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles B. Silva Jr M.D.

Peninsula Regional Medical Center Salisbury MD

31. Date filed (Month, Day, Year)

JAN 23 2008

32. Registrar's Signature

*[Signature]*

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02868

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Annabelle Hurley

2. Date of Death  
Month Day Year  
January 20 20083. Time of Death  
10:07 a.m.

4a. Facility Name (If not institution, give street and number)

Mallard Bay Care Center

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral  
Director

5. Social Security Number

213-22-5462

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

8. Date of Birth (Month, Day, Year)

July 29, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

906 Oakley Terrace

10f. Zip Code

21613

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

cafeteria manager

16b. Kind of Business/Industry

public school

17. Father's Name (First, Middle, Last)

Herbert Moore

18. Mother's Name (First, Middle, Maiden Surname)

Hazel Dykes

19a. Informant's Name/Relationship (Type, Print)

Mark Hurley son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8606 Red Pheasant Court, Houston, TX 77040

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

East New Market Cem.

Date

1/23/08

20c. Location - City or Town, State

East New Market, MD

21. Signature of Funeral Service Licensee

B. K. R.

22. Name and Address of Facility

Thomas Funeral Home P.A.

700 Locust St., Cambridge, MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Small Cell Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, Dyslipidemia, Hypertension  
urinary tract infection

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lois A. NARR D.O.

29c. License number

H 44615

29d. Date signed (Month, Day, Year)

1/22/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lois A. NARR D.O.

100 Bramble ST

Cambridge

31. Date filed (Month, Day, Year)

JAN 23 2008

32. Registrar's Signature

John A. Jones

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02869

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Melvin Sylvester Haskins</b>   |  |  |  | 2. Date of Death<br>Month <b>JAN.</b> Day <b>15</b> Year <b>2008</b>   |  |  |  | 3. Time of Death<br><b>3:00 A<sup>M</sup></b>               |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Talbot Hospice House</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Easton</b>  |  |  |  | 4c. County of Death<br><b>Talbot</b>                        |  |
| 5. Social Security Number<br><b>219-44-2051</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>APR 1 28, 1946</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
| 10a. State<br><b>MD</b>   |  |  |  | 10b. County<br><b>Talbot</b>   |  | 10c. City, Town or Location<br><b>Royal Oak</b>  |  |   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>6841 Bellevue Road</b>  |  | 10f. Zip Code<br><b>21662</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                 |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Caretaker</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Private Residence</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>James Albert Haskins</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Mackey</b>  |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Vera Haskins</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 474, Royal Oak, Maryland 21662</b>  |  |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Royal Oak Cemetery</b>  |  | Date<br><b>1/19/08</b>   |  | 20c. Location - City or Town, State<br><b>Royal Oak, Maryland</b>  |  |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Janelle C. Henry</b>  |  |  |  | 22. Name and Address of Facility<br><b>HENRY FUNERAL HOME, P.A.<br/>510 Washington St. Cambridge, Maryland 21613</b>   |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Lung Ca.</b>   |  |  |  | Approximate Interval Between Onset and Death<br><b>3 mos.</b>  |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |  |  | a. Due to (or as a consequence of):  |  |  |  |   |  |
|   |  |  |  | b. Due to (or as a consequence of):  |  |  |  |   |  |
|   |  |  |  | c. Due to (or as a consequence of):  |  |  |  |   |  |
|   |  |  |  | d. Due to (or as a consequence of):  |  |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death<br><input type="checkbox"/> Unknown  |  | 3. Ectopic pregnancy<br><input type="checkbox"/> Other (specify)   |  | 23d. Date of delivery<br>Month Day Year  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |  |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                           |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>David Smith</b>  |  | 29c. License number<br><b>D39587</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>1/17/08</b>  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David H. Smith, M.D., 8221 Teal Drive, Ste. 302, Easton, MD 21601</b>  |  |  |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 18 2008</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |  |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02870

Physician/  
Medical Examiner1. For State  
Registrar

1. Decedent's Name (First, Middle, Last)

DAVID MICHAEL KIRSCH, SR

2. Date of Death

Month Day Year  
January 22, 2008

3. Time of Death

1445 hrs

4a. Facility Name (if not institution, give street and number)

5925 Setter Drive

4b. City, Town, or Location of Death

Elkridge

4c. County of Death

Howard

5. Social Security Number

212-70-0696

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

10/06/1957

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

HOWARD

10c. City, Town or Location

ELKRIDGE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5925 SETTER DRIVE

10f. Zip Code

21075

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

APPLIANCE TECHNICIAN

16b. Kind of Business/Industry

APPLIANCE REPAIR

17. Father's Name (First, Middle, Last)

IRVIN KIRSCH

18. Mother's Name (First, Middle, Maiden Surname)

MARY BLACK

19a. Informant's Name/Relationship (Type, Print)

DAVID MICHAEL KIRSCH, JR / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

341 PIONEER DR. OAK GROVE, KY 42262

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN MEMORIAL PARK

Date

01/31/2008

20c. Location - City or Town, State

EASTON, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FELLOWS, HELPENBEIN & NEWNAM FUNERAL HOME, P.A.  
408 SOUTH LIBERTY STREET CENTREVILLE, MD 21617

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED☐ AMENDED

#23a, 27, per ME, 877 3/10/08 TT

IF FEMALE:  
23b. Was decedent pregnant in the past 12 months?1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 23, 2008

30. Name and address of person who completed cause of death (Item 23a)

David Fowler M.D. Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 29 2008

32. Registrar's Signature

[Signature]

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02871

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>MURRAY KISHTER</b>   |  |  |  | 2. Date of Death<br>Month <b>January</b> Day <b>14</b> Year <b>2008</b>  |  |   |  | 3. Time of Death<br><b>4:56 P M</b>  |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Baltimore Washington Medical Center</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>   |  |   |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |  |  |
| 5. Social Security Number<br><b>217-22-5652</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>12/20/1925</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>                                    |  |  |  |
| Usual Residence of Decedent   |  |  |  |  |  |   |  |  |  |  |  |
| 10a. State<br><b>FL</b>   |  | 10b. County<br><b>Palm Beach</b>   |  | 10c. City, Town or Location<br><b>West Palm Beach</b>  |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br><b>5294 Tiffany Anne Circle</b>   |  |  |  | 10f. Zip Code<br><b>33417</b>  |  |   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>2</b>   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Jewelry Designer</b>   |  |   |  | 16b. Kind of Business/Industry<br><b>Jewelry</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Irving Kishter</b>  |  |  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rose Fastoff</b>  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Adele Y. Kishter - Wife</b>  |  |  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5294 Tiffany Anne Circle West Palm Beach FL 33417</b> |  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garden of Remembrance Memorial Park</b>   |  | Date<br><b>1/17/08</b>  |  | 20c. Location - City or Town, State<br><b>Clarksburg, MD</b>                                   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |  |  |  |  | 22. Name and Address of Facility<br><b>Danzansky-Goldberg Memorial Chapels, Inc.<br/>1170 Rockville Pike Rockville MD 20852</b>                           |  |  |  |  |  |

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death<br><b>3 WEEKS</b><br><b>20 YEARS</b>      |  |  |  |
| a. <b>ISCHEMIC COLITIS</b><br>Due to (or as a consequence of):<br>b. <b>SEVERE PERIPHERAL VASCULAR DISEASE</b><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____   |  |   |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown    |  | 23d. Date of delivery<br>Month _____ Day _____ Year _____                              |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES, PACEMAKER PLACEMENT</b>   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|  |  | 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                          |  | 29b. Signature and title of certifier<br><b>Guillermo José Gíngreco, MD</b>   |  | 29c. License number<br><b>00062714</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JANUARY 14, 2008</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GUILLERMO JOSÉ GÍNGRECO 301 HOSPITAL DRIVE, GLEN BURNIE, MD 20611</b>   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 18 2008</b>  |  | 32. Registrar's Signature<br>   |  |  |  |  |  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02872

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Winifred Maxine Leydorf</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>January 15, 2008</b>  |  | 3. Time of Death<br><b>3:32 P M</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>  |  |
| 5. Social Security Number<br><b>019-22-5318</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs. | 8. Date of Birth (Month, Day, Year)<br><b>April 18, 1918</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>                                     |  |
| 10a. State<br><b>Maryland</b>   |  |   |  | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Annapolis</b>   |  |
| 10e. Street and Number<br><b>4223 River Crescent Drive</b>  |  |   |  | 10f. Zip Code<br><b>21401</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+) <b>4</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Mathias Vogelpohl</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Luetta Linkhart</b>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Glenn C. Leydorf/son</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>909 Echo Bay Court Gambrills, Maryland 21054</b>   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glen Haven Mem. Park</b>   |  | 20c. Date<br><b>1/21/2008</b>  |  | 20d. Location - City or Town, State<br><b>Glen Burnie, Maryland</b>                         |  |
| 21. Signature of Funeral Service Licensee<br><b>Fodd E. Hille</b>   |  |   |  | 22. Name and Address of Facility<br><b>John M. Taylor Funeral Home<br/>147 Duke of Gloucester St., Annapolis, MD 21401</b>   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cerebral Infarction</b>  |  |   |  | Approximate Interval Between Onset and Death<br><b>3 days</b>  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Parkinsons Disease</b>   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |  |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br><b>Joseph Fried M.D.</b>   |  |   |  | 29c. License number<br><b>D17965</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>1/17/2008</b>                                     |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joseph Fried 116 Defense Hwy Annapolis, Md. 21401</b>  |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 17 2008</b>   |  |   |  | 32. Registrar's Signature<br><b>Kevin H. Smith</b>   |  |   |  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02873

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

James Christopher Lenox

2. Date of Death

Month Day Year  
January 11, 2008

3. Time of Death

9:20 P M

4a. Facility Name (If not institution, give street and number)

1108 Moderno Ct.

4b. City, Town, or Location of Death

Crofton

4c. County of Death

Anne Arundel

5. Social Security Number

216-60-1183

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
1/02/1954

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1108 Moderno Ct.

10f. Zip Code

21114

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Gas Line Repairman

16b. Kind of Business/Industry

Washington Gas

17. Father's Name (First, Middle, Last)

Joseph James Lenox

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Robinson

19a. Informant's Name/Relationship (Type, Print)

Sharon S. Lenox/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1108 Moderno Ct., Crofton, MD 21114

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Our Lady of Sorrows

Date

1/19/08

20c. Location - City or Town, State

West River, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home  
2973 Solomons Island Rd. Edgewater, MD 21037

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9.5 Years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

D39505

29d. Date signed (Month, Day, Year)

January 14, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yudhish Markan 305 Hospital Dr. Glen Burnie, MD. 21061

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02874

1- For  
State  
Registrar

|   |   |  |  |  |   |   |  |  |  |  |
|---|---|--|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Dorothy Gould Lewis</b>  |  |  |  | 2. Date of Death<br>Month <b>January</b> Day <b>18</b> Year <b>2008</b>   |   |  |  | 3. Time of Death<br><b>3:35 a.m.</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Mallard Bay Care Center</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Cambridge</b>  |   |  |  | 4c. County of Death<br><b>Dorchester</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-07-8292</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>March 27, 1919</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
|   | Usual Residence of Decedent   |  |  |  | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Dorchester</b>                             |  | 10c. City, Town or Location<br><b>Cambridge</b>  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>602 Water Street</b>   |   |  |  | 10f. Zip Code<br><b>21613</b>  |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |   |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)   |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>assistant manager</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>bank</b>   |   |  |  | 17. Father's Name (First, Middle, Last)<br><b>Henry Lloyd Gould</b>  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Verdyne Willey</b>  |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ann Webster daughter</b>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6066 Todd Point Road, Cambridge, MD 21613</b>  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland Veterans Cem.</b>   |   |  |  | 20c. Location - City or Town, State<br><b>1/22/08 Hurlock, MD</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>B.K.B.</b>  |  |  |  | 22. Name and Address of Facility<br><b>Thomas Funeral Home P.A.<br/>700 Locust St., Cambridge, MD 21613</b>   |   |  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Metastatic Ovarian Cancer</b>  |  |
|   | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)                                       |   |  |  | 23d. Date of delivery<br>Month Day Year  |  |
|   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |
| 28a. Date of Injury (Month, Day Year)   |   |  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |
| 29b. Signature and title of certifier<br><b>[Signature] MD</b>  |   |  |  | 29c. License number<br><b>047924</b>   |   |   |  | 29d. Date signed (Month, Day, Year)<br><b>1-18-08</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>NORMAN TITMUS 503 RYAN ST CAMBRIDGE MD 21613</b> |   |  |  | 31. Date filed (Month, Day, Year)<br><b>JAN 22 2008</b>                      |   |   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02875

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Harriet Elizabeth Lulie

2. Date of Death

January 25, 2008

3. Time of Death

1:20 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

5634 Poole Road

4b. City, Town, or Location of Death

Jefferson

4c. County of Death

Frederick

5. Social Security Number

068-46-4183

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56 Yrs.

8. Date of Birth (Month, Day, Year)

Dec. 13, 1951

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Jefferson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5634 Poole Road P.O. Box 626

10f. Zip Code

21755

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Attorney

16b. Kind of Business/Industry

Law

17. Father's Name (First, Middle, Last)

William B.D. Harris

18. Mother's Name (First, Middle, Maiden Surname)

Harriet Miller Washburn

19a. Informant's Name/Relationship (Type. Print)

Edward Lulie III (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5634 Poole Rd. P.O. Box 626 Jefferson, MD 21755

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Date

January 28, 2008

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

Jeffrey Lee Davis M01414

22. Name and Address of Facility

J.L. Davis Funeral Home

12525 Bradbury Ave. Smithsburg, Maryland 21783

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Papillary Renal cell Carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown

N/A

3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

N/A

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

N/A

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

N/A

28b. Time of Injury

N/A

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

N/A

28d. Describe how injury occurred

N/A

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

Andrew Lulie

29c. License number

D0064568

29d. Date signed (Month, Day, Year)

1-28-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIVIAN DEHOSA 610 North Ave, Brunswick, MD 21774

31. Date filed (Month, Day, Year)

FEB 04 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

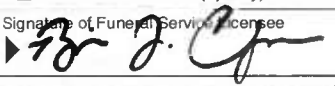
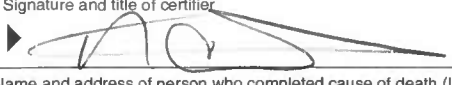
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02876

1- For  
State  
Registrar

|  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Wesley J. McClaren</b>  |  |  |  | 2. Date of Death<br>Month <b>January</b> Day <b>13</b> Year <b>2008</b>  |  | 3. Time of Death<br><b>5:25pm</b>                                       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Atria- Manresa</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>                              |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>487-28-0303</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs. | 8. Date of Birth<br>Month <b>4</b> Day <b>22</b> Year <b>1921</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MO</b>                   |  |
|  | Usual Residence of Decedent  |  |  |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b>                                      |  |
| To Be Completed by Funeral Director  | 10c. City, Town or Location<br><b>Annapolis</b>  |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
|  | 10e. Street and Number<br><b>1040 Lake Claire Dr.</b>  |  |  |  | 10f. Zip Code<br><b>21409</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1945-1972</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Captain</b>  |  | 16b. Kind of Business/Industry<br><b>US Navy</b>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Wesley James McClaren</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Leatha L. Honaker</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Anne McClaren Wife</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1040 Lake Claire Dr. Annapolis, MD 21409</b>   |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>   |  | Date<br><b>1/15/2008</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>             |  |
|  | 21. Signature of Funeral Service licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>Hardesty Funeral Home, P.A.<br/>12 Ridgely Ave. Annapolis, MD 21401</b>   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Atrial Fibrillation</b><br>Due to (or as a consequence of):<br><b>b. Coronary artery</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b>                               |  |  |  |  |  |   |  |
|  | 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year |  |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Parental minor abuse</b>  |  |  |  |  |  |  |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |  |  |  |   |  |
| 26. Place of Death (Check only one)<br>27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined<br>28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>29b. Signature and title of certifier<br><br>29c. License number<br><b>D23557</b><br>29d. Date signed (Month, Day, Year)<br><b>January 15, 2008</b>                          |  |  |  |  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Caputo 139 Old Solomons Island Rd. Annapolis, MD 21401</b>  |  |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 17 2008</b><br>32. Registrar's Signature<br>  |  |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0036

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Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2008 02877

1- For State Registrar

|   |  |   |  |                                  |  |  |  |  |  |  |
|---|--|---|--|----------------------------------|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Robert McCune Means  |   |  |                                  | 2. Date of Death<br>Month January Day 18 Year 2008   |  |  |  | 3. Time of Death<br>03:48 M  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Montgomery General Hospital  |   |  |                                  | 4b. City, Town, or Location of Death<br>Olney  |  |  |  | 4c. County of Death<br>Montgomery  |  |
| Funeral<br>Director   | 5. Social Security Number<br>183-12-4535   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |                                  | 7. Age (In yrs. last birthday)<br>86 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Mar. 28 1921              |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania   |  |
|   | Usual Residence of Decedent  |   |  |                                  |  |  |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>Md.  |   | 10b. County<br>Montgomery  |                                  | 10c. City, Town or Location<br>Gaithersburg  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br>20920 Delta Drive  |   |  |                                  | 10f. Zip Code<br>20882   |  | 10g. Citizen of What Country?<br>United States                   |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII |                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2  |   |  |                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Budget Analyst  |  | 16b. Kind of Business/Industry<br>U. S. Government               |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Chalmers P. Means   |   |  |                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth McCune  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Elizabeth M. Means / Wife  |   |  |                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>20920 Delta Drive, Gaithersburg, Md. 20882  |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crem.   |                                  | Date<br>1/19/08  |  | 20c. Location - City or Town, State<br>Alexandria, Va.           |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>Muriel H. Barber  |   |  |                                  | 22. Name and Address of Facility<br>Muriel H. Barber Funeral Home<br>P. O. Box 5038, Laytonsville, Md. 20882   |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. PNEUMONIA<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br>DAYS            |   |  |                                  |  |  |  |  |  |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year |   |  |                                  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>MYOCARDIAL INFARCTION   |  |   |  |                                  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M         |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>E. H. H.   |  | 29c. License number<br>H 0065661 |  | 29d. Date signed (Month, Day, Year)<br>1/18/2008                                     |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Deborah Stew, DO 18101 Prince Philip Drive Olney, MD 20832  |  |   |  |                                  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JAN 22 2008  |  | 32. Registrar's Signature<br>K. B. Sparks   |  |                                  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02878

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Paul Medford Newcomb

2. Date of Death

January 21 2008

3. Time of Death

1:15 a.m.

4a. Facility Name (If not institution, give street and number)

4131 Maple Dam Road

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

220-12-0804

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 16 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4131 Maple Dam Road

10f. Zip Code

21613

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

stationary engineer

16b. Kind of Business/Industry

hospital

17. Father's Name (First, Middle, Last)

George Medford Newcomb

18. Mother's Name (First, Middle, Maiden Surname)

Vivian Fitzhugh

19a. Informant's Name/Relationship (Type, Print)

Sara Smith daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4131 Maple Dam Road, Cambridge, MD 21613

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dorchester Mem. Park

Date

1/24/08

20c. Location - City or Town, State

Cambridge, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Thomas Funeral Home P.A.

700 Locust St., Cambridge, MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Coronary Artery Disease*

Due to (or as a consequence of):

b. *Coronary Artery Disease*

Due to (or as a consequence of):

c. *Advanced Parkinsonism*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 min

10 yrs

10 yrs

IF FEMALE:

23b. Was decedent pregnant

In the past 12 months?

☐ Yes ☒ No☐ Yes ☐ No ☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D26388

29d. Date signed (Month, Day, Year)

Jan 23 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Paddelew MD 302 Collins Ave Hurlbuck MD 21643

31. Date filed (Month, Day, Year)

JAN 23 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02879

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rolf-Dietrich Owe

2. Date of Death

Month 1/13/2008 Day Year

3. Time of Death

6:15am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Spa Creek Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

110-28-4266

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 5/2/1927

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

930 Bay Forest Ct. A-111

10f. Zip Code

21403

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Cutlery

17. Father's Name (First, Middle, Last)

Johann Owe

18. Mother's Name (First, Middle, Maiden Surname)

Anna Richard

19a. Informant's Name/Relationship (Type, Print)

Manfred Owe Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8483 Kings Meade Way Columbia, MD 21046

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

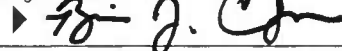
Date

1/15/2008

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

▶ 

22. Name and Address of Facility Hardesty Funeral Home, P.A.

12 Ridgely Ave. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Failure to thrive

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ 

29c. License number

D57028

29d. Date signed (Month, Day, Year)

1/14/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aditya Chopra, M.D. 600 Ridgely Ave. #231 Annapolis, MD 21401

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature



Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02880

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Grace Helen Pettigrew

2. Date of Death

Jan. 15, 2008

3. Time of Death

11:10P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Homewood at Crumland Farms

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

198-26-9452

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

June 2, 1935

9. Birthplace (State or Foreign)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Middletown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4206 Granite Dr.

10f. Zip Code

21769

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

supervisor

16b. Kind of Business/Industry

social science  
research

17. Father's Name (First, Middle, Last)

James Flynn

18. Mother's Name (First, Middle, Maiden Sumame)

Grace Garrison

19a. Informant's Name/Relationship (Type, Print)

Lynn Wood (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2021 Chapel Ct., Frederick, MD 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, funeral home, or other place)

Arlington National 2/7/08

Date

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald B. Thompson Funeral Home  
31 E. Main St., Middletown, MD 2176923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Metastatic Carcinosarcoma Uterus

Approximate  
Interval Between  
Onset and Death

2 yrs

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D36421

29d. Date signed (Month, Day, Year)

1/16/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Amerena 9093 Ridgely Dr. #104 Frederick, MD 21701

31. Date filed (Month, Day, Year)

JAN 22 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02881

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GERALDINE FRANCES ROTOLONE

2. Date of Death

January 17, 2008

3. Time of Death

7:30 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Heartfields at Frederick

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

345-24-3566

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 5, 1930

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1820 Latham Road

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. Do NOT use retired)

Nurse

16b. Kind of Business/Industry

Nursing

17. Father's Name (First, Middle, Last)

Roy Truex

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Williams

19a. Informant's Name/Relationship (Type, Print)

Jeff Rototone / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1731 Algonquin Road, Frederick, Maryland 21701

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

1/18/08

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ROBERT E. DAILEY & SON, FUNERAL HOMES, P.A.  
1201 NORTH MARKET ST., FREDERICK, MD 2170123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Squamous cell cancer mandible

Approximate  
Interval Between  
Onset and Death

4 months

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Assisted

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

Living Facility

29a. Certifier  
(Check only  
one)29b. Signature and title of certifier  
Helen N. Smith

29c. License number

D57643

29d. Date signed (Month, Day, Year)

1.18.08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

65 E Thomas Thompson Dr Frederick MD 21702

31. Date filed (Month, Day, Year)

JAN 22 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02882

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>Agnes Boi Sheriff   |  | 2. Date of Death<br>Month Day Year<br>January 12, 2008  |  | 3. Time of Death<br>11:31p <sup>M</sup>  |  |
| 4a. Facility Name (If not institution, give street and number)<br>5506 Western Avenue   |  | 4b. City, Town, or Location of Death<br>Chevy Chase   |  | 4c. County of Death<br>Montgomery  |  |
| 5. Social Security Number<br>577-21-8328  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>49yrs   | 8. Date of Birth (Month, Day, Year)<br>4/12/58   | 9. Birthplace (State or Foreign Country)<br>Sierra Leone   |  |
| Usual Residence of Decedent   |  |   |  |  |  |
| 10a. State<br>MD  | 10b. County<br>Montgomery  | 10c. City, Town or Location<br>Silver Spring  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 10e. Street and Number<br>3 Manchester Place  |  | 10f. Zip Code<br>20901  |  | 10g. Citizen of What Country?<br>United States   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:        |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: African  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+) 2yrs  |  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>LPN  |  | 16b. Kind of Business/Industry<br>Health  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Koligo Mossima   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ballay Kamara   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Bashirr Sheriff (spouse)  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3 Manchester Place, Silver Spring, MD 20901 |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mokondeh Village Cem.   |  | 20c. Location - City or Town, State<br>Sierra Leone  |  |
| 21. Signature of Funeral Service Licensee<br>Annie Thompson   |  | 22. Name and Address of Facility<br>McGuire Funeral Service, Inc.<br>7400 Georgia Avenue, NW, Washington DC 20012   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Probable stroke<br>Due to (or as a consequence of):<br>b. Hypertensive arteriosclerotic disease<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br>DME |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death<br>5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown     |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) workplace |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |
| 29b. Signature and title of certifier<br>Don Breckner M.D.  |  | 29c. License number<br>D00428   |  | 29d. Date signed (Month, Day, Year)<br>Jan 16 2008   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>IRA N BRECKNER MD MME Silver Spring MD 20902  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JAN 18 2008  |  | 32. Registrar's Signature<br>Brian K. Spivey  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02883

1- For  
State  
Registrar

|   |  |  |   |  |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Marian M. Snowberger</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>January 13, 2008</b>  |  |   |  | 3. Time of Death<br><b>12:30 pm</b>  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>660 Old Herald Harbor Road</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Crownsville</b>   |  |   |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>218-09-1146</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct 18, 1917</b>                      |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |  |  |  |
|   | Usual Residence of Decedent  |  |   |  |  |  |   |  |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Crownsville</b>  |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |
|   | 10e. Street and Number<br><b>660 Old Herald Harbor Road</b>  |  |   |  | 10f. Zip Code<br><b>21032</b>  |  |   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Alfred Marion Friend</b>   |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hallie Mae Thompson</b> |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Daniel Snowberger Son</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>660 Old Herald Harbor Rd. Crownsville, MD 21032</b>  |  |   |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glen Haven Cemetery</b>   |  | Date<br><b>1/18/2008</b>  |  | 20c. Location - City or Town, State<br><b>Glen Burnie, MD</b>                                      |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Hardesty Funeral Home, P.A.<br/>12 Ridgely Ave. Annapolis, MD 21401</b>   |  |   |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br>b. <b>CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br>c. <b>HYPERTENSION</b><br>Due to (or as a consequence of):<br>d. <b>DIABETES</b> |  |   |  |  |  |   |  |  |  |  |  |
|   | Approximate Interval Between Onset and Death<br><b>MINUTES</b><br><b>~ 12 years</b><br><b>715 years</b>  |  |   |  |  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |  |  |  |  |
|   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  |   |  |  |  |   |  |  |  |  |  |
|   | 23d. Date of delivery<br>Month Day Year  |  |   |  |  |  |   |  |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CAROTID ARTERY DISEASE</b><br><b>PERIPHERAL VASCULAR DISEASE</b>  |  |   |  |  |  |   |  |  |  |  |  |
|   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |  |  |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |  |   |  |  |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |  |  |  |  |
|   | 26. Place of Death Check only one<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |   |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |   |  |  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day Year)  |  |   |  |  |  |   |  |  |  |  |  |
|   | 28b. Time of Injury<br><b>M</b>  |  |   |  |  |  |   |  |  |  |  |  |
|   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |  |   |  |  |  |  |  |
|   | 28d. Describe how injury occurred  |  |   |  |  |  |   |  |  |  |  |  |
|   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |   |  |  |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |   |  |  |  |  |  |
|   | 29b. Signature and title of certifier<br>  |  |   |  |  |  |   |  |  |  |  |  |
|   | 29c. License number<br><b>D57325</b>   |  |   |  |  |  |   |  |  |  |  |  |
|   | 29d. Date signed (Month, Day, Year)<br><b>1/15/08</b>  |  |   |  |  |  |   |  |  |  |  |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SHAWNA SALIETHI<br/>8028 RITCHEE HWY, STE 108, PANDENA, MD 21222</b>  |  |   |  |  |  |   |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>JAN 17 2008</b>  |  |   |  | 32. Registrar's Signature<br>  |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

5CH

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

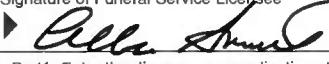
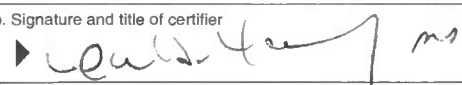
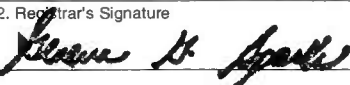
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02884

1- For  
State  
Registrar

|   |  |   |  |  |  |  |   |                                   |
|---|--|---|--|--|--|--|---|-----------------------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Liane Lucie Schutz</b>                                |   |  |  | 2. Date of Death<br>Month Day Year<br><b>JANUARY 15 2008</b> |  | 3. Time of Death<br><b>7:10 A M</b>                             |                                   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Doctor's Community Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Lanham</b>        |  | 4c. County of Death<br><b>Prince George's</b>                   |                                   |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-56-5130</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                               | 8. Date of Birth<br>(Month, Day, Year)<br><b>Jan. 28, 1937</b>   | 9. Birthplace (State or Foreign Country)<br><b>Germany</b>      |                                   |
|   | Usual Residence of Decedent  |   |  |  |  |  |   |                                   |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Bowie</b>  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |                                   |
| 10e. Street and Number<br><b>12106 Wilmont Turn</b>   |  |   |  | 10f. Zip Code<br><b>20715</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |                                   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |                                   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College (1-4or 5+)</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Home Maker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |                                   |
| 17. Father's Name (First, Middle, Last)<br><b>Alfred Uhlemann</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Honi Lorenz</b>  |  |  |   |                                   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Deirdre Smee/ Daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1415 Kinghaven Court Gambrills, MD 21054</b>   |  |  |   |                                   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sacred Heart Catholic Church Cemetery</b>  |  | Date<br><b>1/19/2008</b>   |  | 20c. Location - City or Town, State<br><b>Bowie, MD</b>  |   |                                   |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Robert E. Evans Funeral Home<br/>16000 Annapolis Road Bowie, MD 20715</b>   |  |  |   |                                   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Carcinoma of the lung with metastases to the liver</b><br>Due to (or as a consequence of):<br>b. <b>metastases to the liver</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Due to (or as a consequence of): |  |   |  |  |  |  | Approximate Interval Between Onset and Death<br><b>5 months</b> |                                   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year  |   |                                   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>hypertension, chronic obstructive pulmonary disease, peripheral artery disease</b>   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |                                   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)    |  |  |  |  |   |                                   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>920579</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>January 16, 2008</b>   |   |                                   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Don't Tablante, 2104 Executive Place, #502, Lanham, MD 20702</b>   |  |   |  |  |  |  |   |                                   |
| 31. Date filed (Month, Day, Year)<br><b>JAN 17 2008</b>   |  | 32. Registrar's Signature<br>  |  |  |  |  |   |                                   |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02885

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Messinger Savage

2. Date of Death

Month Day Year  
January 12, 2008

3. Time of Death

11:55 P. M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Candlelight Cove Assisted Living

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

577-14-7147

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 3, 1916

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

Easton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1200 S. Washington Street Apt. 703

10f. Zip Code

21601

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cartographer

16b. Kind of Business/Industry

U. S. Department of  
Commerce

17. Father's Name (First, Middle, Last)

Charles Harrison Savage

18. Mother's Name (First, Middle, Maiden Surname)

Mary Sarah Messinger

19a. Informant's Name/Relationship (Type, Print)

Kathryn H. Savage/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1200 S. Washington St., Apt. 703, Easton, MD 21601

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

1/14/2008

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

▶

22. Name and Address of Facility

Robert E. Evans Funeral Home,  
16000 Annapolis Road, Bowie, Maryland 2071523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Prostate Cancer  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 yrs

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ MD

29c. License number

D0066270

29d. Date signed (Month, Day, Year)

1/13/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8221 Teal Dr. Easton, MD 21601, David Halberson, MD.

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02886

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Francis Simpson, Jr.

2. Date of Death

Month

Day

Year

3. Time of Death

0940 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

579-48-8812

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

07/03/1921

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

14997 Health Center #257

10f. Zip Code

20716

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: '46-'48

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Physician

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

William F. Simpson, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Anita T. Orlando

19a. Informant's Name/Relationship (Type, Print)

David M. Simpson/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2796 Spring Lakes Drive, Davidsonville, Md 21035

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven

Date

01/15/2008

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Robert E. Evans Funeral Home

16000 Annapolis Road, Bowie, Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Heart Failure, Congestive

Approximate Interval Between Onset and Death

3 1/2

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acute Myocardial Infarction

3 1/2

c. Atherosclerotic Cardiovascular Disease

year

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 21438

29d. Date signed (Month, Day, Year)

January 11, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL J. LARENTIS 445 DENISE HIGHWAY ANNAPOLIS MD 21401

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02887

1- For  
State  
Registrar

|  |  |  |  |   |  |                          |   |   |  |                                   |  |  |  |
|--|--|--|--|---|--|--------------------------|---|---|--|-----------------------------------|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Harrison Spriggs</b>  |  |  |   | 2. Date of Death<br>Month Day Year<br><b>January 9 2008</b>  |                          |   |   | 3. Time of Death<br><b>5:30 P<sup>M</sup></b>  |                                   |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b>   |  |  |   | 4b. City, Town, or Location of Death<br><b>Annapolis</b>   |                          |   |   | 4c. County of Death<br><b>Anne Arundel</b>   |                                   |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-14-4993</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br><b>91 Yrs.</b>   |                          | 8. Date of Birth (Month, Day, Year)<br><b>July 16 1916</b>                    |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |                                   |  |  |  |
|  | Usual Residence of Decedent  |  |  |   |  |                          |   |   |  |                                   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Anne Arundel</b>   |   | 10c. City, Town or Location<br><b>Annapolis</b>  |                          |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                   |  |  |  |
|  | 10e. Street and Number<br><b>2091 Forest Dr.</b>   |  |  |   | 10f. Zip Code<br><b>21401</b>  |                          |   |   | 10g. Citizen of What Country?<br><b>USA</b>  |                                   |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1957-61</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                          |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |                                   |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>7th</b>  |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Brick Mason</b>  |                          |   |   | 16b. Kind of Business/Industry<br><b>Self Employed</b>   |                                   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Thomas Spriggs</b>   |  |  |   |  |                          | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Unobtainable</b> |   |  |                                   |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ruth E. Spriggs (Wife)</b>  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2091 Forest Dr. Annapolis, Md. 21401</b>   |                          |   |   |  |                                   |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland Veteran</b>  |                          |   |   | 20c. Location - City or Town, State<br><b>1-16-08 Crownsville, Md.</b>                         |                                   |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Jerry H. Reese MD0483</b>  |  |  |   | Funeral Home Name and Address of Facility<br><b>Reese &amp; Sons Mortuary, P.A.<br/>821 West St. Annapolis, Md. 21401</b>  |                          |   |   |  |                                   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Homorrhagic stroke</b>   |  |  |   |  |                          |   |   |  |                                   |  |  |  |
|  | 23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |  |   |  |                          |   |   |  |                                   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  |  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |                          |   | 23d. Date of delivery<br>Month Day Year   |  |                                   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |                          |   |   |  |                                   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  |   |  |                          |   |   |  |                                   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                          |   |   |  |                                   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                          |   |   |  |                                   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred |  |  |  |
|  |  |  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                          |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |                                   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |                          |   |   |  |                                   |  |  |  |
| 29b. Signature and title of certifier<br><b>[Signature] MD</b>   |  |  |  | 29c. License number<br><b>D55187</b>  |  |                          |   | 29d. Date signed (Month, Day, Year)<br><b>1/14/08</b>                                       |  |                                   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Anne Arundel Medical Center</b>   |  |  |  |   |  |                          |   |   |  |                                   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 16 2008</b>  |  |  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |                          |   |   |  |                                   |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2008 02888

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jane Planitzer Snider

2. Date of Death  
Month Day Year  
January 17, 20083. Time of Death  
2:34a MFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Kline Hospice House

4b. City, Town, or Location of Death

Mt. Airy

4c. County of Death

Frederick

5. Social Security Number

029-28-6502

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68

8. Date of Birth (Month, Day, Year)

March 18, 1939

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Walkersville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

261 Providence Circle

10f. Zip Code

21793

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Social Worker

16b. Kind of Business/Industry

Health Department

17. Father's Name (First, Middle, Last)

Rudolph Planitzer

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Hinz

19a. Informant's Name/Relationship (Type, Print)

Linwood F. Snider Jr./ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

261 Providence Circle, Walkersville Maryland 21793

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Stauffer Crematory Inc 1/19/2008

Date

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

*Stadel & DeGrupe*

22. Name and Address of Facility

Stauffer Funeral Home P. A.  
1621 Opossumtown Pike, Frederick, MD 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Coronary Heart Failure*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Pulmonary Fibrosis*  
*Cardiomyopathy*  
*Severe aortic disease*

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice Home

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Ann E. Becker MD*

29c. License number

D30496

29d. Date signed (Month, Day, Year)

1/18/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Francis E. Becker MD; 300 W. 9th St; Frederick, MD 21701

31. Date filed (Month, Day, Year)

JAN 22 2008

32. Registrar's Signature

*Ann E. Becker*

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02889

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Antoine Shaheen

2. Date of Death

January 14, 2008

3. Time of Death

3:58 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

213-06-8764

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 16, 1932

9. Birthplace (State or Foreign Country)

Syria

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Laurel

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7303 Summerwind Circle

10f. Zip Code

20707

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Banker

16b. Kind of Business/Industry

Financial

17. Father's Name (First, Middle, Last)

Amin Shaheen

18. Mother's Name (First, Middle, Maiden Surname)

Hennene Saad

19a. Informant's Name/Relationship (Type, Print)

Nabil Shaheen/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10016 Fall Rain Drive Laurel, MD 20723

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory 01/18/08

Date

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Beverly L. Heckrotte

MO1251

22. Name and Address of Facility

Going Home Cremation Service P.O. Box 784

Beverly L. Heckrotte, P.A. Clarksville, MD 21029

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hip Fracture

Due to (or as a consequence of):

b. Sepsis

Due to (or as a consequence of):

c. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death  
☐ Pregnant at time of death  
☐ Unknown☐ Ectopic pregnancy☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation  
☒ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

12/29/07

28b. Time of Injury

1:12 PM

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

at home

28d. Describe how injury occurred

slipper got caught in chair

subject tripped and fell

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Laurel, MD

7303 Summerwind Circle

29a. Certifier (Check only one)

☒ Physician☐ Medical Examiner

29b. Signature and title of certifier

Sima Nourani Zenuz, M.D. 8600 Old Georgetown Rd. Bethesda, MD 20814

29c. License number

D0065182

29d. Date signed (Month, Day, Year)

1/16/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sima Nourani Zenuz, M.D. 8600 Old Georgetown Rd. Bethesda, MD 20814

31. Date filed (Month, Day, Year)

JAN 18 2008

32. Registrar's Signature

Sima Nourani Zenuz

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10 E.G.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02890

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Laura Jane Schap

2. Date of Death

January 16 2008

3. Time of Death

12:20p. M

4a. Facility Name (If not institution, give street and number)

Deer's Head Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

209-22-5324

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 30, 1927

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6172 Ayrshire Drive

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

nurse

16b. Kind of Business/Industry

hospital

17. Father's Name (First, Middle, Last)

Lawrence Hiliav

18. Mother's Name (First, Middle, Maiden Surname)

Marie unknown

19a. Informant's Name/Relationship (Type, Print)

Attison Barnes p.r.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

28230 Connelly Point Rd, Trappe, MD 21673

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Dorchester Mem. Park

Date

1/21/08

20c. Location - City or Town, State

Cambridge, MD

21. Signature of Funeral Service Licensee

B. K. B.

22. Name and Address of Facility

Thomas Funeral Home P.A.

700 Locust St., Cambridge, MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

pneumonia

Due to (or as a consequence of):

persistent urinary tract infection

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and DeathSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. K. B.

29c. License number

H 66064

29d. Date signed (Month, Day, Year)

01/23/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TONY GONSALVES, D.O. DEER'S HEAD HOSPITAL CENTER

31. Date filed (Month, Day, Year)

JAN 23 2008

32. Registrar's Signature

B. K. B.

State  
RegistrarBaltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
office.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02891

1- For State Registrar Amend PI line a-c, 25, per ME, 877 3/108-77 Certificate of Death

Reg. No.

|   |   |   |   |  |  |   |   |   |   |   |
|---|---|---|---|--|--|---|---|---|---|---|
| Physician /Medical Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Augustine Saldana</b>  |   | 2. Date of Death<br>Month <b>January</b> Day <b>13</b> Year <b>2008</b>   |  | 3. Time of Death<br><b>20:30</b> <sup>P</sup>  |   |   |   |   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Peninsula Regional Medical Center</b>  |   | 4b. City, Town, or Location of Death<br><b>Salisbury, MD</b>  |  | 4c. County of Death<br><b>Wicomico</b>   |   |   |   |   |   |
| Funeral Director  | 5. Social Security Number<br><b>None</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>42</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>April 24, 1965</b>   | 9. Birthplace (State or Foreign Country)<br><b>Mexico</b>                                      |   |   |   |   |   |
|   | Usual Residence of Decedent   |   |   |  |  |   |   |   |   |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Wicomico</b>  | 10c. City, Town or Location<br><b>Salisbury</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |   |   |   |   |
|   | 10e. Street and Number<br><b>523 Winder Street, Apt. A</b>  |   | 10f. Zip Code<br><b>21801</b>   |  | 10g. Citizen of What Country?<br><b>Mexico</b>   |   |   |   |   |   |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Mexican</b> |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |   |   |   |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Maintenance Worker</b>  |  | 16b. Kind of Business/Industry<br><b>Department Store</b>                                      |   |   |   |   |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Susano Saldana</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Patricia Nava</b>   |  |  |   |   |   |   |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Sister Agnes Oman/Friend</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>418 Wicomico Street, Salisbury, MD 21801</b>  |  |  |   |   |   |   |   |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crematory of Delmarva</b>  | Date<br><b>1/16/2008</b>   | 20c. Location - City or Town, State<br><b>Delmar, Delaware</b>                                 |   |   |   |   |   |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   | 22. Name and Address of Facility<br><b>Zeller Funeral Home, P. O. Box 3171<br/>1212 Old Ocean City Road, Salisbury, MD 21802</b>  |  |  |   |   |   |   |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Complications of antituberculosis treatment</b>  |   |   |  |  |   |   |   |   |   |
|   | <table border="0"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)<br/><br/>                 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a. <del>acute renal failure</del><br/>Due to (or as a consequence of):</td> <td rowspan="4">                 Approximate Interval Between Onset and Death<br/><br/> <b>days</b><br/><br/> <b>weeks</b> </td> </tr> <tr> <td>b. <del>predominant liver failure</del><br/>Due to (or as a consequence of):</td> </tr> <tr> <td>c. <del>drug toxicity (INH)</del><br/>Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____<br/>Due to (or as a consequence of):</td> </tr> </table> |   |   |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <del>acute renal failure</del><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><br><b>days</b><br><br><b>weeks</b> | b. <del>predominant liver failure</del><br>Due to (or as a consequence of): | c. <del>drug toxicity (INH)</del><br>Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a. <del>acute renal failure</del><br>Due to (or as a consequence of):   | Approximate Interval Between Onset and Death<br><br><b>days</b><br><br><b>weeks</b>   |   |  |  |   |   |   |   |   |
|   | b. <del>predominant liver failure</del><br>Due to (or as a consequence of):   |   |   |  |  |   |   |   |   |   |
|   | c. <del>drug toxicity (INH)</del><br>Due to (or as a consequence of):   |   |   |  |  |   |   |   |   |   |
|   | d. _____<br>Due to (or as a consequence of):  |   |   |  |  |   |   |   |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown       |   | 23d. Date of delivery<br>Month _____ Day _____ Year _____  |  |   |   |   |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |   |   |   |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |   |   |   |   |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |   |   |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br>M _____  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred  |   |   |   |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   |  |  |   |   |   |   |   |
| 29c. License number<br><b>D59931</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>1/14/08</b>   |   |  |  |   |   |   |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Brett Hofmann 100 E. Carroll St. Salisbury, Md. 21801</b>  |   |   |   |  |  |   |   |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>JAN 18 2008</b>   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |   |   |   |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2008 02892

1- For State Registrar

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**State Registrar**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Richard Jerman Sockriter, Jr.</b>  |  | 2. Date of Death<br>Month <b>Jan.</b> Day <b>15</b> Year <b>2008</b>  |   | 3. Time of Death<br><b>6:11PM M</b>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>600 West Railroad Avenue, Apt. 14</b>  |  | 4b. City, Town, or Location of Death<br><b>Salisbury</b>  |   | 4c. County of Death<br><b>Wicomico</b>   |   |
| 5. Social Security Number<br><b>212-72-0683</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>48</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 28, 1959</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
| Usual Residence of Decedent   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |
| 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Wicomico</b>   | 10c. City, Town or Location<br><b>Salisbury</b>   |   |  |   |
| 10e. Street and Number<br><b>600 West Railroad Avenue, Apt. 14</b>  |  | 10f. Zip Code<br><b>21802</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housekeeping</b>  |   | 16b. Kind of Business/Industry<br><b>College</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Richard Jerman Sockriter, Sr.</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillie Mae Norman</b>   |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Terry Hupfer/Sister</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2301 Meadow Drive, Salisbury, MD 21804</b>  |   |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crematory of Delmarva</b>  |   | 20c. Location - City or Town, State<br><b>Delmar, Delaware</b>   |   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Zeller Funeral Home, P. O. Box 3171<br/>1212 Old Ocean City Road, Salisbury, MD 21802</b>  |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ASCD</b>  |  | Approximate Interval Between Onset and Death  |   |  |   |
| Immediate Cause (Final disease or condition resulting in death)   |  |   |   |  |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |   |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown    |   | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>H50497</b>   |   |
| 29d. Date signed (Month, Day, Year)<br><b>1/16/08</b>   |  |   |   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Chris Snider 100 E. Carroll St. Salisbury, MD 21801</b>  |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JAN 18 2008</b>   |  | 32. Registrar's Signature<br>   |   |  |   |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02893

amend item

1- For State Registrar #7 per fh, 01/22/08, eb

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

MERLYN BRITTINGHAM SHAW

2. Date of Death

January 21, 2008

3. Time of Death

5:45 A M

4a. Facility Name (If not institution, give street and number)

26378 East Pear Street

4b. City, Town, or Location of Death

Crisfield

4c. County of Death

Somerset

5. Social Security Number

577-60-7702

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 67 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 4, 1943

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Somerset

10c. City, Town or Location

Crisfield

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

26378 East Pear Street

10f. Zip Code

21817

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Somerset County  
Developmental Center

17. Father's Name (First, Middle, Last)

George F. Brittingham

18. Mother's Name (First, Middle, Maiden Surname)

Inez Thews

19a. Informant's Name/Relationship (Type, Print)

William Homer Wilson (Companion)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26378 East Pear Street - Crisfield, MD 21817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Grace Episcopal Church  
Cemetery

Date

1/26/08

20c. Location - City or Town, State

Purdy, Virginia

21. Signature of Funeral Service Licensee

Robert H. Bradshaw, Jr.

22. Name and Address of Facility

Bradshaw & Sons Funeral Home  
306 W. Main St. - Crisfield, MD 2181723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

a. Due to (or as a consequence of):

Myocardial Attack

b. Due to (or as a consequence of):

Coronary Artery Disease

c. Due to (or as a consequence of):

Insulin Dependent Diabetes

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

&lt; 24

&gt; 1 yr - 1 mo

&gt; 5 yr - 1 mo

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

Valvular Heart Disease, S/P replacement  
Adrenal Insufficiency  
Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

27. Manner of death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

26. Place of Death (Check only one)

4 ☒ Nursing HomeResidence 6 ☐ Other (Specify)

29a. Certifier

(Check only one)

2 ☒ Medical Examiner

29b. Signature and title of certifier

John D. Whittaker, M.D.

29c. License number

D0053262

29d. Date signed (Month, Day, Year)

01-22-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John D. Whittaker, M.D. - 305 10th Street - Pocomoke City, MD 21851

31. Date filed (Month, Day, Year)

JAN 22 2008

32. Registrar's Signature

Heaven &amp; Sons

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2008 02894

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LAWRENCE TOM

2. Date of Death  
Month Day Year

1 16 08

3. Time of Death

4:10 AM

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY, MD

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

071-12-0288

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

8. Date of Birth (Month, Day, Year)

February 22, 1922

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12800 Littleton Street

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian Chinese

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Restaurant Manager/Owner

16b. Kind of Business/Industry

Hotel &amp; Restaurant

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Mary Tom - Daughter-In-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12800 Littleton Street, Silver Spring, Maryland 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

01/19/2008

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home, Inc.  
11800 New Hampshire Avenue, Silver Spring, Maryland 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death  
DAYS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

H 0065661

29d. Date signed (Month, Day, Year)

1/16/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah Stein, D.O. 18101 Prince Philip Drive Olney, MD 20832

31. Date filed (Month, Day, Year)

JAN 18 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02895

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |   |  |  |  |
|---|--|---|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Joseph John Tessitore</b>  |  | 2. Date of Death<br>Month <b>1</b> / Day <b>14</b> / Year <b>2008</b>   |   | 3. Time of Death<br><b>10:30am</b>   |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>163 Friar Tuck Rd.</b>   |  | 4b. City, Town, or Location of Death<br><b>Sherwood Forest</b>  |   | 4c. County of Death<br><b>Anne Arundel</b>   |  |  |
| 5. Social Security Number<br><b>154-32-0481</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>1/13/1941</b>                       |  | 9. Birthplace (State or Foreign Country)<br><b>NY</b>  |  |
| Usual Residence of Decedent   |  |   |   |  |  |  |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>Anne Arundel</b>   | 10c. City, Town or Location<br><b>Sherwood Forest</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 10e. Street and Number<br><b>163 Friar Tuck Rd.</b>   |  | 10f. Zip Code<br><b>21405</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |   |  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Property Manager</b>  |  | 16b. Kind of Business/Industry<br><b>Import/Export</b>  |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Frank Tessitore</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Philameno Fabiano</b> |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Marguerite Tessitore Wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>163 Friar Tuck Rd. Sherwood Forest, MD 21405</b>  |   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Hardesty Funeral Home, P.A.<br/>12 Ridgely Ave. Annapolis, MD 21401</b>  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>ARRHYTHMIA</b><br>Due to (or as a consequence of):<br>b. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  | Approximate Interval Between Onset and Death   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death<br><input type="checkbox"/> Unknown   |   | 23d. Date of delivery<br>Month Day Year  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CONGESTIVE HEART FAILURE</b>   |  |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br><b>M</b>   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D 0461776</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>JANUARY 15, 2008</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Brian Wolf, M.D. 116 Defense Hwy Suite 400 Annapolis, MD 21401</b>   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 17 2008</b>   |  | 32. Registrar's Signature<br>   |   |  |  |  |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02896

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gertrude Louise Turner

2. Date of Death

01/11/2008

3. Time of Death

3:00PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Bowie Health Care Center

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

5. Social Security Number

579-26-2097

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

8. Date of Birth (Month, Day, Year)

06/24/1917

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12110 Tawny Lane

10f. Zip Code

20715

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Edward Barton

18. Mother's Name (First, Middle, Maiden Surname)

Philomena Clark

19a. Informant's Name/Relationship (Type, Print)

Donna M. King/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12110 Tawny Lane, Bowie, Maryland 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakemont Memorial Gardens

Date

01/18/2008

20c. Location - City or Town, State

Davidsonville, Maryland

21. Signature of Funeral Service Licensee

Robert E. Evans Funeral Home

22. Name and Address of Facility

16000 Annapolis Road, Bowie, Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolus

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jan MD

29c. License number

D0053709

29d. Date signed (Month, Day, Year)

JAN 15th 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAS CITIZEN 14300 Gallant Fox Lane STE # 210 Bowie

State Registrar

31. Date filed (Month, Day, Year)

JAN 16 2008

32. Registrar's Signature

Jan MD

MD 20715

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



amend line 23a, a-b Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

per phy amend item 23c per doc 881 7-9-08 vt State of Maryland Department of Health and Mental Hygiene

aaco hlth dept State Registrar 01/28/08 dlw

Certificate of Death

Reg. No. 2008 02897

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Miriam Scott Utgoff

2. Date of Death

Month Day Year  
January 12, 2008

3. Time of Death

5:40 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2 Ridge Road

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

067-38-5341

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth (Month, Day, Year)

Dec. 5, 1916

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2 Ridge Road

10f. Zip Code

21401

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married

☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Thomas A. Scott

18. Mother's Name (First, Middle, Maiden Surname)

Rebekah Wilmer

19a. Informant's Name/Relationship (Type, Print)

Vadym W. Utgoff / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3616 51st. NW. Edmonton, Alberta Canada T6L1C6

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington Nat'l Cem.

Date

2/29/2008

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

*Michael J. Blum*

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc.

147 Duke of Gloucester St. Annapolis, MD 21401

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Liver Failure

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

Lymphoma

b. Due to (or as a consequence of):

Renal Failure

c. Due to (or as a consequence of):

Renal Failure

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No

☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death

☐ Pregnant at time of death

☐ Unknown

☐ Ectopic pregnancy

☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lung Tumor

Breast Cancer

ASCAD

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation

☐ Accident ☐ Could not be determined

☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Robert M. Greenfield ASD*

29c. License number

026373

29d. Date signed (Month, Day, Year)

1/14/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert M. Greenfield

139 Old Scharon's Isl Rd

Annapolis, Md 21401

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

*Ann H. Smith*

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02898

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alvin E. Wilson

2. Date of Death

Jan. 16 2008

3. Time of Death

10:17A<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

St. Thomas More Nursing Home

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George's

5. Social Security Number

577-72-2156

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 9, 1953

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, DC

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5042 13th Street N.E

10f. Zip Code

20018

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Communication

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

George W. Wilson

18. Mother's Name (First, Middle, Maiden Surname)

Katherine E. Jackson

19a. Informant's Name/Relationship (Type, Print) Mother  
Katherine E. Wilson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5042 13th Street N.E Wash, DC, 20018

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Riverdale Cemetery

Date

1/18/08

20c. Location - City or Town, State

Riverdale, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Genesis Cremation And Funeral Services  
5732 Georgia Ave., N.W Wash, DC 20011

23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Human Immunodeficiency Virus / AIDS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D01852

29d. Date signed (Month, Day, Year)

January 16 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul A. DeVore, MD 4203 Queensbury Rd Hyattsville MD 20781

31. Date filed (Month, Day, Year)

JAN 18 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02899

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Roxie White

2. Date of Death  
Month Day Year

01/16/08

3. Time of Death

7:30pm<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

218-24-0736

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

8. Date of Birth (Month, Day, Year)

06/27/1927

9. Birthplace (State or Foreign Country)

Va.

Usual Residence of Decedent

10a. State

Md

10b. County

Prince George

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6427 24 Place

10f. Zip Code

20782

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Insurance Co.

17. Father's Name (First, Middle, Last)

Henry A. Jackson

18. Mother's Name (First, Middle, Maiden Surname)

Ethel White

19a. Informant's Name/Relationship (Type, Print)

Jeannette P. Lee Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7003 East Forest Rd Landover, Md 20781

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glenwood Cemetery

Date

01/22/08

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Snead Mortuary Service, P.A.

1409 Fairlakes Pl Ste B Mitchellville, Md

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death 20783

Immediate Cause (Final disease or condition resulting in death)

a. Severe Pneumonia

Due to (or as a consequence of):

b. Cerebrovascular Disease

Due to (or as a consequence of):

c. Atrial Filtration

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D63579

29d. Date signed (Month, Day, Year)

01/16/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr Maria Tayag

1500 Forest Glen Road

Silver, Spring, Md 20910

31. Date filed (Month, Day, Year)

JAN 18 2008

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02900

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia Ann Adamski

2. Date of Death

FEBRUARY 4, 2008

3. Time of Death

01:12P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

217-26-6078

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

June 26, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Carney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3042 Third Ave.

10f. Zip Code

21234

10g. Citizen of What Country?

United States Of America

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4or 5+)  
N/A16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

At Home

17. Father's Name (First, Middle, Last)

Clarence E. Zieler

18. Mother's Name (First, Middle, Maiden Surname)

Ruby V. Soper

19a. Informant's Name/Relationship (Type, Print)

Steven E. Adamski- Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7898 Aiken Ave. Parkville, Md., 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gardens Of Faith Cemetery

Date

Feb. 9, 2008

20c. Location - City or Town, State

Rosedale, Maryland

21. Signature of Funeral Service Licensee

Patricia Ann Bachelder

22. Name and Address of Facility

EVANS FUNERAL CHAPEL & CREMATION SERVICES  
8800 Harford RD., Parkville MD., 2123423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. MALIGNANT PLEURAL EFFUSIONS

Due to (or as a consequence of):

LARGE B-CELL LYMPHOMA

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Timothy Low M.D.

29c. License number

D24034

29d. Date signed (Month, Day, Year)

2/4/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMOTHY LOW, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

Kevin B. Ford

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 23b show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02901

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Paul H. Argabright, Sr.

2. Date of Death

February 1 2008

3. Time of Death

11:30 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

233-28-2618

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 5, 1917

9. Birthplace (State or Foreign Country)

Bluefield, WV

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8403 A Nunley Drive

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Director of Parts Division

16b. Kind of Business/Industry

General Motors

17. Father's Name (First, Middle, Last)

Herbert Argabright

18. Mother's Name (First, Middle, Maiden Surname)

Unknown Kroger

19a. Informant's Name/Relationship (Type, Print)

Paul Argabright, Jr. - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1420 N Street NW, Washington DC 20005

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cemetery

Date

2/4/08

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Kimberly G. Zupotay

22. Name and Address of Facility

8200 HARKFORD RD, BALTIMORE, MD 21234. Evans Funeral Chapel - Cremation Services - Parkville

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE ON CHRONIC RENAL FAILURE

SEVERE METABOLIC ACIDOSIS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

ATTENDING PHYSICIAN

29c. License number

D0060039

29d. Date signed (Month, Day, Year)

FEBRUARY 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. MAW N-00  
GOOD SAMARITAN HOSPITAL, BALTIMOREState  
Registrar

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, 351

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar amend #20b Per G876 2/05/08 JH  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death  
Reg. No. 2008 02902

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, ✓

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JESSIE B. ALEXANDER</b>  |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>02</b> Year <b>2008</b>   |  | 3. Time of Death<br><b>7:50P</b> M   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>GILCHRIST CENTER FOR HOSPICE</b>   |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| 5. Social Security Number<br><b>243-58-0984</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>7/04/1940</b>                      | 9. Birthplace (State or Foreign Country)<br><b>N. CAROLINA</b>   |  |
| Usual Residence of Decedent   |  |  |  |  |  |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>N/A</b>  | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>4816 GWYNN OAK AVENUE</b>  |  | 10f. Zip Code<br><b>21207</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+)   |  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PROFESSIONAL DRY CLEANER</b>  |  | 16b. Kind of Business/Industry<br><b>DRY CLEANING BUSINESS</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>JOHN WHITE</b>  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNE MAE BULLOCK</b> |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MCKENLEY ALEXANDER / SON</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>813 HOPEWOOD ROAD, PIKESVILLE, MD 21208</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lorraine Park Cem.</b>  |  | 20c. Location - City or Town, State<br><b>GWYNN OAK, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Lung Cancer</b><br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |  |  |  |  |
| 23b. If FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  |  |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)   |  |  |  |  |  |
| 23d. Date of delivery<br>Month Day Year   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>hospice</b> |  |  |  |
| 27. Manner of death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                       |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D 58303</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 3 2008</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>AMON CHARLES JR 6701 N-Charles St Towson MD 21204</b>  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>   |  | 32. Registrar's Signature<br>  |  |  |  |



## Certificate of Death

Reg. No. 2008 02903

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carole Ann Bayne

2. Date of Death

Month Day Year  
01 29 2008

3. Time of Death

6:45 AM

4a. Facility Name (If not institution, give street and number)

Baltimore Washington Medical Center

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

214-40-2168

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

If Under 24 Hrs.

Months Days

Hours Min.

8. Date of Birth (Month, Day, Year)

Apr. 9, 1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Lansdowne

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4202 Hollins Ferry Road

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Landscape Company

17. Father's Name (First, Middle, Last)

William Schech

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Berry

19a. Informant's Name/Relationship (Type, Print)

Alan Bayne - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7720 Vena Court, Pasadena, MD 21122

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

West Arundel  
Crematory

Date

2-1-2008

20c. Location - City or Town, State

Odenton, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ambrose Funeral Home, Inc.  
2719 Hammonds Fry Rd., Lansdowne, MD 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory arrest  
Due to (or as a consequence of):

b. Respiratory Insufficiency  
Due to (or as a consequence of):

c. Chronic Asthma with Status  
Due to (or as a consequence of): Asthmaticus

d.

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Subclinical Hypothyroidism

Dyslipidemia

Osteoporosis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Calderon

29c. License number

D 26456

29d. Date signed (Month, Day, Year)

01/29/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JORGE E. CALDERON, M.D. - 4000 ANNAPOLIS RD, Baltimore, MD 21227

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

Jorge E. Calderon

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland - Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02904

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MATTIE BENNETT

2. Date of Death

FEBRUARY 3 2008

3. Time of Death

07:36 AM

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

231-16-2277

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

January 15, 1918

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8136 Cornwall Road

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8 years

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Foritz

18. Mother's Name (First, Middle, Maiden Surname)

Vera Thomas

19a. Informant's Name/Relationship (Type, Print)

Dick Lance Bennett Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8136 Cornwall Road, Dundalk, Maryland 21222

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory

Date

February 4, 2008

20c. Location - City or Town, State

Baltimore City, MD.

21. Signature of Funeral Service Licensee

Anthony Connelly

22. Name and Address of Facility

Connelly Funeral Home of Dundalk, P.A.  
7110 Sollers Point Road, Dundalk, MD. 21222

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HYPOVOLEMIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DAYS

23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. DECREASED ORAL INTAKE AND ANOREXIA

Due to (or as a consequence of):

MONTHS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David Spragg MD

29c. License number

D0064724

29d. Date signed (Month, Day, Year)

February 3, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID SPRAGG MD

4940 EASTERN AVENUE BALTIMORE MD 21224

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02905

## Certificate of Death


Reg. No.

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |  |  |  |   |  |  |
|---|--|--|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Florence May Burrows</b>   |  |  | 2. Date of Death<br>Month Day Year<br><b>February 2, 2008</b>  |  | 3. Time of Death<br><b>6:00 A<sup>M</sup></b> |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Gilchrist Center</b>   |  |  | 4b. City, Town, or Location of Death<br><b>Towson</b>  |  | 4c. County of Death<br><b>Baltimore</b>       |  |  |
| 5. Social Security Number<br><b>218-14-5225</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>July 30, 1923</b>                          |  |
| 9. Birthplace (State or Foreign Country)<br><b>Minnesota</b>  |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>  |   | 10c. City, Town or Location<br><b>Timonium</b>                                       |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>210 Charmuth Road</b>   |  | 10f. Zip Code<br><b>21093</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>1</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Albert Martin Johnson</b>   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alice B. Lunstrom</b>  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>David Burrows (son)</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1720 Fleet Street, Baltimore, MD 21231</b> |  |   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem. Gardens</b>   |  | 20c. Location - City or Town, State<br><b>Timonium, MD</b>   |   | 20d. Date<br><b>02/05/2008</b>   |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Road Towson, Maryland 21204</b>  |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Ischemic Cardomyopathy</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br><b>years</b> |  |  |  |  |   |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |  |  |  |   |  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown   |  |  |  |  |   |  |  |
| 23d. Date of delivery<br>Month Day Year   |  |  |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |  |  |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>hospice</b> |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>058303</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 2 2008</b>  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>AARON J. CHARLES MD 6701 N. Clarke St Towson MD 21204</b>  |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>   |  | 32. Registrar's Signature<br>   |  |  |   |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-r show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

7

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02906

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William J. Blueford

2. Date of Death

Month Day Year  
JANUARY 28, 2008

3. Time of Death

10:45AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

St. Agnes HealthCare

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

218-01-1171

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91

8. Date of Birth (Month, Day, Year)

March 7, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

513 Herberts Run

10f. Zip Code

21228

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7 years

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

President

16b. Kind of Business/Industry

Cummins Radiator Co.

17. Father's Name (First, Middle, Last)

William J. Blueford, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Johanna Wolfram

19a. Informant's Name/Relationship (Type, Print)

Joan B. Blueford (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6451 N. Charles St. Unit 331 Baltimore, MD 21214

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Bayview Crematory

Date

2-1-2008

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

J. Wayne Osterling

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.A.  
130 E. Fort Ave. Baltimore, MD 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

20 MINUTES

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Chloe L. Smith MD

29c. License number

D0051865

29d. Date signed (Month, Day, Year)

January 28, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES CURTIS ST AGNES HOSPITAL, BALTIMORE

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

James H. Smith

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitBlueford, William J.  
Division of Vital Records, P.O. Box 68760, 2State  
Registrar

1- For State  
Registrar

Certificate of Death

Reg. No.

|   |  |  |  |  |   |  |
|---|--|--|--|--|---|--|
| Physician/<br>Medical Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Frederic Crosby Bartter, Jr.</b>  |  | 2. Date of Death<br>Month Day Year<br><b>February 1, 2008</b>  |  | 3. Time of Death<br><b>1508 hrs</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>2821 St. Paul Street, Apt. 4</b>  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>N/A</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-62-2228</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F             | 7. Age (In yrs. last birthday)<br><b>59</b> Yrs.   | 8. Date of Birth (MM/DD/YYYY)<br><b>July 13, 1948</b>                        |   | 9. Birthplace (State or Foreign)<br><b>Massachusetts</b>                             |
|   | Usual Residence of Decedent  |  |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>N/A</b>  | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|   | 10e. Street and Number<br><b>2821 St. Paul Street 3rd Floor #4</b>   |  | 10f. Zip Code<br><b>21218</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                               |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: |  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Writer</b>                           |  | 16b. Kind of Business/Industry<br><b>Freelance</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Dr. Frederic C. Bartter, Sr.</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jane L. Lillard</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jane Bartter Mother</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>227 Primrose Place, San Antonio, Texas 78209</b> |  |   |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>   |  | 20c. Location - City or Town, State<br><b>2/4/2008 Catonsville, MD</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Lynn B. Henss</i>  |  | 22. Name and Address of Facility<br><b>Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland</b>                          |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) a. <b>Hypertensive Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><input type="checkbox"/> UNPENED <input type="checkbox"/> AMENDED |  |  |  |   |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  |  |  |  |   |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown   |  |  |  |  |   |  |
| 23d. Date of delivery<br>Month Day Year   |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b>  |  |  |  |  |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |  |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene  |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br><i>Ana Rubio</i>   |  | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 2, 2008</b>               |   |  |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 03 2008</b>   |  |  |  |  |   |  |
| 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |   |  |

Baltimore, MD 21215-0036

Physician  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02908

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alva Blake more

2. Date of Death

02-02-2008

3. Time of Death

10:55 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore, Maryland

4c. County of Death

Baltimore City

5. Social Security Number

220-14-4461

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

8. Date of Birth

03/27/1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1650 Woodbourne Avenue Apt. 409

10f. Zip Code

21239

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bank Clerk

16b. Kind of Business/Industry

Banking Industry

17. Father's Name (First, Middle, Last)

Joseph Blakemore

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Akers

19a. Informant's Name/Relationship (Type. Print)

Georgia Martin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1931 Walnut Avenue Baltimore, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

2/6/08

20c. Location - City or Town, State

Parkville, Maryland

21. Signature of Funeral Service Licensee

Charles J. Minny

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Road

Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. septic shock

Due to (or as a consequence of):

b. clostridium difficile colitis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

12 hours

5 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

rheumatoid arthritis

hypothyroidism

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Olga Lurye, MD

29c. License number

D0065145

29d. Date signed (Month, Day, Year)

02-02-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Olga Lurye, MD, 5601 Loch Raven Blvd, Baltimore, MD 21239

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02909

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Earl L. Butz

2. Date of Death

Month Day Year  
February 2, 2008

3. Time of Death

8:20 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

3906 Dresden Street

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

5. Social Security Number

311-07-8191

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

98

8. Date of Birth (Month, Day, Year)

July 3, 1909

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Indiana

10b. County

Tippecanoe

10c. City, Town or Location

W. Lafayette

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2741 N. Salisbury Street

10f. Zip Code

47906

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

University Dean

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Herman Lee Butz

18. Mother's Name (First, Middle, Maiden Surname)

Ada Lower

19a. Informant's Name/Relationship (Type, Print)

William P. Butz/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3906 Dresden Street, Kensington, Maryland 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Tippecanoe Memory Gardens

Date

February 9, 2008

20c. Location - City or Town, State

W. Lafayette, Indiana

21. Signature of Funeral Service Licensed

William A. Humphrey

M01173

22. Name and Address of Facility

Robert A. Humphrey Funeral Home, Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Son's Residence

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Stephen R. Fahey, M.D.

29c. License number

D26478

29d. Date signed (Month, Day, Year)

February 2, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen R. Fahey, M.D. UofMD Health Center Campus Drive, College Park, MD 20742

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02910

1- For  
State  
Registrar

|   |   |  |   |  |  |  |  |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>SHARON ANN BEALL</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 2, 2008</b>  |  |  |  | 3. Time of Death<br><b>8:10 A<sup>M</sup></b>  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>UPPER CHESAPEAKE MEDICAL CENTER</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BEL AIR</b>   |  |  |  | 4c. County of Death<br><b>HARFORD</b>  |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>219-60-7369</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>June 5, 1946</b>                           |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |  |  |
|   | Usual Residence of Decedent   |  |   |  |  |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Joppa</b>  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |
|   | 10e. Street and Number<br><b>2524 Mountain Road</b>   |  |   |  | 10f. Zip Code<br><b>21085</b>  |  |  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Never Worked</b>   |  |  |  | 16b. Kind of Business/Industry   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Cecil Hubert Beall</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Icile Myrtle Boggs</b>   |  |  |  |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carole B. Sniegowski / Sister</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2524 Mountain Road, Joppa, Maryland 21085</b>  |  |  |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Moreland Memorial Park 2-5-08</b>   |  |  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                                  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Charles D. Engel</i>  |  |   |  | 22. Name and Address of Facility<br><b>McComas Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, Maryland 21009</b>  |  |  |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Bilateral Pneumonia</b><br>Due to (or as a consequence of):<br>b. <b>Sepsis</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death |  |   |  |  |  |  |  |  |  |  |  |
|   | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |  |  |  |  |
|   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown   |  |   |  |  |  |  |  |  |  |  |  |
|   | 23d. Date of delivery<br>Month Day Year   |  |   |  |  |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  |  |  |  |  |
|   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |  |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |  |  |  |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |  |
|   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |  |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |  |  |  |  |
| State Registrar                               | 29b. Signature and title of certifier<br><i>[Signature]</i> MD  |  |   |  | 29c. License number<br><b>D60768</b>   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>02/02/2008</b>   |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>M. Jokhadari, 500 Upper Chesapeake Drive, Bel Air, MD 21014</b>  |  |   |  |  |  |  |  |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>   |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |  |  |  |  |

## Certificate of Death

Reg. No.

2008 0291

Physician/  
Medical Examiner1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

CARLA ELAINE BARRON-DUNN

2. Date of Death

Month Day Year  
January 26, 2008

3. Time of Death

0931 hrs

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

620 Coachmans Way

4b. City, Town, or Location of Death

Parkton

4c. County of Death

Baltimore County

5. Social Security Number

214-78-5931

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

8. Date of Birth (MM/DD/YYYY)

08/16/1960

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

PARKTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

620 COACHMANS WAY

10f. Zip Code

21120

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

VICE PRES. BENEFIT OPERATIONS REAL LIFE-H.

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

PALMA VALDIVIA

18. Mother's Name (First, Middle, Maiden Surname)

DORIS JANES

19a. Informant's Name/Relationship (Type, Print)

WAYNE G. DUNN (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

620 COACHMANS WAY PARKTON, MD. 21120.

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

GREEN MOUNT CREMATORY 01/29/08 BALTO CITY, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service/Licensee

22. Name and Address of Facility

HENRY W. JENKINS &amp; SONS CO.

16924 YORK RD MONKTON, MD. 21111.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Occlusive Pulmonary Thromboembolism

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Lower Extremity Deep Venous Thrombosis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions

contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 27, 2008

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

State  
Registrar

OCME

ORIGINAL

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 10g, 17 per inf 876 2-14-08 vt  
State of Maryland, Department of Health and Mental Hygiene

1- For State Registrar Amend #30, per DVR, 876, 2/5/08 TT Certificate of Death

Reg. No. 2008 02912

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |  |  |
|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ITA</b>  |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>1</b> Year <b>2008</b>   |  | 3. Time of Death<br><b>2:45P M</b>   |
| 4a. Facility Name (If not institution, give street and number)<br><b>SUBURBAN HOSPITAL</b>  |  | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>   |  | 4c. County of Death<br><b>MONTGOMERY</b>   |
| 5. Social Security Number<br><b>214-71-3064</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>06/20/1922</b> | 9. Birthplace (State or Foreign Country)<br><b>UKRAINE</b>   |
| Usual Residence of Decedent   |  |   |  |  |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>MONTGOMERY</b>   | 10c. City, Town or Location<br><b>GAITHERSBURG</b>  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
| 10e. Street and Number<br><b>101 ODENDHAL AVENUE, #405</b>  |  | 10f. Zip Code<br><b>20877</b>   |  | 10g. Citizen of What Country?<br><b>Russia</b> <del>USA</del>  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>5+</b>                        |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MEDICAL DOCTOR</b>  |  | 16b. Kind of Business/Industry<br><b>MEDICINE</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><del>MOSHE</del> <b>ABRAM</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>BARG ROSA DIMANT</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ALEXANDER BARG / NEPHEW</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6522 WINNEPEG ROAD, BETHESDA, MD 20817</b>        |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory, or other place)<br><b>JUDEAN MEMORIAL GARDENS</b>   |  | 20c. Location - City or Town, State<br><b>02/04/2008 OLNEY, MD</b>   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>                               |  |  |

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|  |  |   |
|--|--|---|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>ILEUS</b><br>Due to (or as a consequence of):<br><b>ACUTE RENAL FAILURE</b><br>Due to (or as a consequence of):<br><b>SHOCK</b><br>Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____  |
| 23d. Date of delivery<br>Month _____ Day _____ Year _____  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHOLECYSTITIS</b>   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year) _____ 28b. Time of Injury _____ M _____ 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred _____ 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) _____ 28f. Location (Street and Number or Rural Route Number, City or Town, State) _____ |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                          |  | 29b. Signature and title of certifier<br>   |
| 29c. License number<br><b>066066</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2/21/08</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Andrew Leung-Doon Wong, MD Suburban Hospital Bethesda, MD</b>   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>  |  | 32. Registrar's Signature<br>   |

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

#30 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02913

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Wilma Jane Chilcoat

2. Date of Death

February 4, 2008

3. Time of Death

5:30 A M

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

233-46-2255

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 3, 1933

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3317 Elm Avenue

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Telephone Operator

16b. Kind of Business/Industry

Communication

17. Father's Name (First, Middle, Last)

Dorsey Tighe

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Grub

19a. Informant's Name/Relationship (Type, Print)

Raymond E. Chilcoat, Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3317 Elm Avenue Baltimore, Maryland 21211

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc.

Date

02/05/08

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Thomas Gregor

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Road Baltimore, Maryland 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. EDDIE NAKHODA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

State  
RegistrarFEBRUARY 4, 2008 5:30 a.m.  
Baltimore, Maryland 21215-0036WILMA CHILCOAT  
Division or Vital Records, P.O. Box 68760,To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

## Certificate of Death

Reg. No. 2008 02914

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

25

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |                          |  |  |  |  |
|--|--------------------------|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Brian Welford Corbin</b>  |                          | 2. Date of Death<br>Month <b>2</b> Day <b>03</b> Year <b>08</b>  |  | 3. Time of Death<br><b>11:00a M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>1411 Cliftview Ave.</b>   |                          | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>NA</b>   |  |
| 5. Social Security Number<br><b>214-50-4139</b>  | 6. Sex<br><b>1 M 2 F</b> | 7. Age (In yrs. last birthday)<br><b>59</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>11 1 48</b>                    | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |
| Usual Residence of Decedent  |                          |  |  |  |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>NA</b> | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><b>1 X Yes 2 No</b>   |  |
| 10e. Street and Number<br><b>1411 Cliftview Ave.</b>   |                          | 10f. Zip Code<br><b>21213</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A</b>  |  |
| 11. Marital Status<br><b>1 X Never Married 2 Married</b><br><b>3 Widowed 4 Divorced</b>  |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b><br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 X No</b> Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |                          | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4or 5+) <b>BS Degree</b>                                       |  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>  |                          | 16b. Kind of Business/Industry<br><b>Baltimore City Schools</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Johnson Corbin</b>   |                          |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Neonta Smith</b> |  |  |
| 19a. Informant's Name/Relationship (Type. Print)<br><b>LaMarrien Lincoln-Friend Girl</b>   |                          | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1411 Cliftview Ave. Baltimore, MD 21213</b>  |  |  |  |
| 20a. Method of Disposition<br><b>X Burial 2 Cremation 3 Removal from State</b><br><b>4 Donation 5 Other (Specify)</b>  |                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>2/9/08 Lansdown, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>Joseph R. Walters</i>  |                          | 22. Name and Address of Facility<br><b>March F/H East</b><br><b>1101 E. North Ave. Baltimore, MD 21202</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Congestive Heart Failure</b><br>Due to (or as a consequence of):<br><b>b. Ischemic Heart Disease</b><br>Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |                          |  |  |  |  |
| Approximate Interval Between Onset and Death<br><b>1 year</b><br><b>1 year</b>   |                          |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 Yes 2 No</b><br><b>3 Unknown</b>   |                          | 23c. If yes, outcome of pregnancy<br><b>1 Live birth 2 Fetal death</b><br><b>3 Ectopic pregnancy</b><br><b>4 Pregnant at time of death</b><br><b>5 Other (specify)</b><br><b>9 Unknown</b> |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |                          |  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 X Yes 2 No 3 Probably 4 Unknown</b>   |  |
| 24a. Was an autopsy performed?<br><b>1 Yes 2 X No</b>  |                          |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>   |  |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 X No</b>  |                          | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>                                       |  |  |  |
| 27. Manner of Death<br><b>1 X Natural 2 Accident 3 Suicide 4 Homicide</b><br><b>5 Pending investigation 6 Could not be determined</b>  |                          | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><b>1 Yes 2 No</b>  |                          | 28d. Describe how injury occurred  |  |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |                          | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>   |                          |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Stephen Gottlieb, MD</i>   |                          | 29c. License number<br><b>D-36885</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/5/08</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stephen Gottlieb MD 2/5/08 225 Greene St Baltimore, MD</b>  |                          |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>  |                          | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |



**Medical Certification: To Be Completed by Physician/Medical Examiner**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02916

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |                                 |   |  |   |  |
|--|---------------------------------|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Kathryn B. Cole</b>   |                                 | 2. Date of Death<br>Month: <b>2</b> Day: <b>2</b> Year: <b>2008</b>   |  | 3. Time of Death<br><b>10:05 A.M.</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Stella Maris Hospice</b>  |                                 | 4b. City, Town, or Location of Death<br><b>Timonium</b>   |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| 5. Social Security Number<br><b>212-36-4180</b>  | 6. Sex<br><b>1</b> M <b>2</b> F | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>2/8/1938</b> | 9. Birthplace (State or Foreign Country)<br><b>Balt., Maryland</b>  |  |
| Usual Residence of Decedent  |                                 |   |  |   |  |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Baltimore</b> | 10c. City, Town or Location<br><b>Towson</b>  |  | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |  |
| 10e. Street and Number<br><b>722 Milldam Road</b>  |                                 | 10f. Zip Code<br><b>21286</b>   |  | 10g. Citizen of What Country?<br><b>United States of America</b>  |  |
| 11. Marital Status<br><b>3</b> Widowed <b>4</b> Divorced   |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |                                 | 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b> Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>self employed</b>                 |  |
| 16b. Kind of Business/Industry<br><b>professional artist</b>   |                                 | 17. Father's Name (First, Middle, Last)<br><b>Robert Bonsall</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Kathryn Brown</b>   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Kathryn C. Jackson/ daughter</b>  |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>722 Milldam Road Towson, Maryland 21286</b>   |  |   |  |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)  |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Evans Funeral Chapel- Bel Air</b>  |  | 20c. Location - City or Town, State<br><b>Forest Hill, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee<br>  |                                 | 22. Name and Address of Facility<br><b>Peaceful Alternatives Funeral &amp; Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093</b>   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Subarachnoid Hemorrhage</b>  |                                 |   |  |   |  |
| 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Due to (or as a consequence of):</b><br><b>2325 York Road Timonium, Maryland 21093</b>  |                                 |   |  |   |  |
| 23c. If yes, outcome of pregnancy<br><b>1</b> Live birth <b>2</b> Fetal death <b>3</b> Ectopic pregnancy <b>4</b> Pregnant at time of death <b>5</b> Other (specify) <b>9</b> Unknown  |                                 |   |  |   |  |
| 23d. Date of delivery<br>Month: Day: Year:   |                                 |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |                                 |   |  |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown  |                                 |   |  |   |  |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No   |                                 |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No  |                                 |   |  |   |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No   |                                 | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |  |   |  |
| 27. Manner of Death<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide   |                                 | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No   |                                 | 28d. Describe how injury occurred   |  |   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. Certifier (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                 |   |  |   |  |
| 29b. Signature and title of certifier<br>  |                                 | 29c. License number<br><b>916504</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2-4-08</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>  |                                 |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>  |                                 | 32. Registrar's Signature<br>   |  |   |  |

State  
RegistrarFEBRUARY 2, 2008 10:05 a.m.  
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

KATHRYN COLE  
Division of Vital Records, P.O. Box 68760,To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

## State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02917

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas G. Corona

2. Date of Death

Month 2 Day 1 Year 08

3. Time of Death

7:09 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

145-24-9420

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

January 30, 1921

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

66 Rockywood Lane

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 years

College (1-4 or 5+)

4 years

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Graphic Artist

16b. Kind of Business/Industry

Printing

17. Father's Name (First, Middle, Last)

Liborio Corona

18. Mother's Name (First, Middle, Maiden Surname)

Louisa Salamone

19a. Informant's Name/Relationship (Type, Print)

Maria Corona

Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7921 Wise Avenue, Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery

Date

February 5, 2008

20c. Location - City or Town, State

Dundalk, Maryland

21. Signature of Funeral Service Licensee

Anthony Connelly

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk, P.A.  
7110 Sollers Point Road, Dundalk, MD. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY ARTERY DISEASE  
Due to (or as a consequence of):b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE  
Due to (or as a consequence of):c. HYPERTENSION  
Due to (or as a consequence of):d. HYPOTHYROIDISM  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Sairinder K. Tuli MD

29c. License number

D27188

29d. Date signed (Month, Day, Year)

2-4-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR Sairinder K. Tuli 2 Market Place Dundalk MD 21222

31. Date filed (Month, Day, Year)

FEB 05 2008

Registrar's Signature

[Signature]

State Registrar

3

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

## State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02918

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James T. Cash Sr.

2. Date of Death

February 2, 2008

3. Time of Death

11:49 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

St. Agnes Health Care

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

243-36-0658

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

6-9-1928

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Md

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

16 Jackson Ave

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)

Driver

16b. Kind of Business/Industry

City Govt.

17. Father's Name (First, Middle, Last)

Zedrick Cash

18. Mother's Name (First, Middle, Maiden Surname)

Irene Williams

19a. Informant's Name/Relationship (Type, Print)

Curtis Cash son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16 Jackson Ave Glen Burnie, Md. 21061

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmont Crematory

Date

Feb 6, 2008

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Carlton C. Douglas

22. Name and Address of Facility

Carlton C. Douglas's Funeral Service P.A.  
1701 McCulloch St. Balt. Md. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 MINUTES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
☐ Yes ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy performed?  
☐ Yes ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
☐ Yes ☒ No25. Was case referred to medical examiner?  
☐ Yes ☒ No

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Charles Curtis MD

29c. License number

D0051865

29d. Date signed (Month, Day, Year)

FEBRUARY 2, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES CURTIS, MD

ST AGNES HOSPITAL, BALTIMORE

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Cash James T. Sr.  
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02919

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Stephen T. Colburn, Sr.</b>  |   | 2. Date of Death<br>Month Day Year<br><b>January 30, 2008</b>  |  | 3. Time of Death<br><b>12.29 p<sup>M</sup></b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b>  |   | 4b. City, Town, or Location of Death<br><b>Annapolis</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-18-7801</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 26, 1920</b>  |   |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   |  |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Severna Park</b>  |
|   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |   |
|   | 10e. Street and Number<br><b>316 North Drive</b>  |   | 10f. Zip Code<br><b>21146</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:    |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |  |  |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>N/A</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Wireman</b>                          |  | 16b. Kind of Business/Industry<br><b>Westinghouse</b>   |
|   | 17. Father's Name (First, Middle, Last)<br><b>George Colburn</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Barbara Alt</b>  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Marie D. Colburn (Wife)</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>316 North Drive Severna Park, Maryland 21146</b> |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glen Haven Mem. Pk.</b>   |  | 20c. Location - City or Town, State<br><b>Glen Burnie, Maryland</b>   |
|   | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>McCully-Polyniak Funeral Home, P.A.<br/>3204 Mountain Road Pasadena, Maryland 21122</b>                       |  |   |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |   |  |  | Approximate Interval Between Onset and Death  |
|   | Immediate Cause (Final disease or condition resulting in death)<br><b>Myocardial Ischemia</b>   |   |  |  | <b>hours</b>  |
|   | Due to (or as a consequence of):<br><b>Congestive Heart Failure</b>   |   |  |  | <b>days</b>   |
|   | Due to (or as a consequence of):<br><b>Coronary Artery Disease</b>  |   |  |  | <b>years</b>  |
|   | Due to (or as a consequence of):  |   |  |  |   |
|   | Due to (or as a consequence of):  |   |  |  |   |
|   | Due to (or as a consequence of):  |   |  |  |   |
|   | Due to (or as a consequence of):  |   |  |  |   |
|   | Due to (or as a consequence of):  |   |  |  |   |
|   | Due to (or as a consequence of):  |   |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)                                     |  | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atrial Fibrillation</b><br><b>Chronic Renal Failure</b><br><b>Diabetes Mellitus</b>  |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred   |  |  |   |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |  |   |
| 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>DO062749</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>01/31/2008</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Eileen MacDonald, MD</b>   |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>   |   | 32. Registrar's Signature<br>   |  |  |   |



## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WARREN EUGENE COLLINS

2. Date of Death

Month

Day

Year

January 30

2008

3. Time of Death

8:15A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Baltimore-Washington Medical Center

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

414-44-2186

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Feb. 2. 1932

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

43 Chester Circle

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

W.R. Grace &amp; Company

17. Father's Name (First, Middle, Last)

John W. Collins

18. Mother's Name (First, Middle, Maiden Surname)

Nancy Collins

19a. Informant's Name/Relationship (Type, Print)

Joan Collins (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

43 Chester Circle, Glen Burnie, Maryland 21060

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Bayview Crematory

Date

01-31-08

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully-Polyniak Funeral Home P.A.  
3204 Mountain Road, Pasadena, Maryland 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0043977

29d. Date signed (Month, Day, Year)

January 30 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Annelin D. ... 301 Hospital Ave, Glen Burnie, MD. 21060.

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



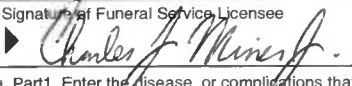
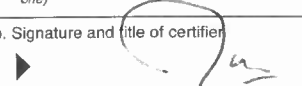

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02921

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |   |  |  |  |   |
|---|--|---|--|--|---|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Margaret Anne Cimino</b>   |  |   |  | 2. Date of Death<br>Month <b>January</b> Day <b>31</b> Year <b>2008</b>  |   |  |  | 3. Time of Death<br><b>5:40 P M</b>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Stella Maris</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Timonium</b>  |   |  |  | 4c. County of Death<br><b>Baltimore</b>  |   |
| 5. Social Security Number<br><b>212-58-8096</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.   |  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                 | 8. Date of Birth (Month, Day, Year)<br><b>05/07/1951</b>                             |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |
| Usual Residence of Decedent   |  |   |  |  |   |  |  |  |   |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |   |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>3825 Bayonne Avenue</b>  |  |   |  | 10f. Zip Code<br><b>21206</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b> |  |  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>                                    |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>John McClaskey</b>  |  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Smith</b>   |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John E. Cimino, Jr. - Husband</b>  |  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3825 Bayonne Avenue Baltimore, Maryland 21206</b> |  |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>   |  | Date<br><b>02/05/2008</b>   |  | 20c. Location - City or Town, State<br><b>Parkville, Maryland</b>                    |  |   |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214</b>   |   |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>metastatic breast cancer</b>   |  |   |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |  |  |   |  |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |   |  |  |   |  |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |
| 23d. Date of delivery<br>Month Day Year   |  |   |  |  |   |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |  |   |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred   |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |   |  |  |  |   |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>D43725</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>2/11/08</b>                                |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. TARIQ MAHMOOD 2300 LULANEY VALLEY RD TIMONIUM MD 21093</b>   |  |   |  |  |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>   |  |   |  | 32. Registrar's Signature<br>   |   |  |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02922

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Celia Knox Crawford

2. Date of Death  
Month Day Year  
February 2, 20083. Time of Death  
4:00 A<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Collingswood Nursing Center

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

253-24-9712

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth  
(Month, Day, Year)

Sept. 11, 1919

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Darnestown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13018 Birdale Lane

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Reuben F. Deese

18. Mother's Name (First, Middle, Maiden Surname)

Attie Mae Freeman

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Fisher/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13018 Birdale Lane, Darnestown, Maryland 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

February 5, 2008

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Robert A. Pumphrey

MO0198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.  
300 West Montgomery Ave., Rockville, MD 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Advanced Dementia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sayed Elsayyad MD

29c. License number

D62435

29d. Date signed (Month, Day, Year)

February 4, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sayed Elsayyad, M.D. 9715 Medical Center Drive #201, Rockville, Maryland 20850

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760, 10

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02923

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

WILLIAM HENRY CROMWELL SR.

2. Date of Death

FEBRUARY 2, 2008

3. Time of Death

22:55 M

4a. Facility Name (If not institution, give street and number)

Upper Chesapeake Medical Center

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

213-28-2705

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

8. Date of Birth (Month, Day, Year)

Mar. 11, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1647 Schucks Road

10f. Zip Code

21015

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Freight Company

17. Father's Name (First, Middle, Last)

John Albert Harris Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Hazel (UNK) (UNK)

19a. Informant's Name/Relationship (Type, Print)

Alma Cromwell / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1647 Schucks Road, Bel Air, Maryland 21015

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

John Wesley UMC Cem 2-7-08

Date

20c. Location - City or Town, State

Abingdon, Maryland

21. Signature of Funeral Service Licensee

Shula Cromwell

22. Name and Address of Facility

McComas Funeral Home, P.A.  
1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 Days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure, Hyperkalemia  
Ischemic Bowel, Lactic Acidosis  
Gastrointestinal Hemorrhage

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Marco Zamora

29c. License number

D40819

29d. Date signed (Month, Day, Year)

February 2, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marco Zamora, MD 500 Upper Chesapeake Drive, Bel Air, 21014

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2008 02921

Physician/  
Medical Examiner  
  
Funeral  
Director

11502  
Baltimore, MD 21215-0036  
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
Medical  
aminer

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

|  |  |   |  |
|--|--|---|--|
| 1- For State Registrar   |  | Reg. No.  |  |
| 1. Decedent's Name (First, Middle, Last)<br><b>Kerry Davis</b>   |  | 2. Date of Death<br>Month Day Year<br><b>February 2, 2008</b>   |  |
| 3. Time of Death<br><b>0610 hrs</b>  |  |   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>4112 Falls Road</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  |
| 4c. County of Death<br><b>N/A</b>  |  |   |  |
| 5. Social Security Number<br><b>215-58-1990</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  |
| 7. Age (In yrs. last birthday)<br><b>55</b> Yrs.   |  | 8. Date of Birth (MM/DD/YYYY)<br><b>JAN 13 1953</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |  |
| 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>4112 Falls Road</b>   |  | 10f. Zip Code<br><b>21211</b>   |  |
| 10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>General Contractor</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Construction</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Francis E. Davis</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clara Binji</b>   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Laurel Davis - niece</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1314 Wildwood Drive, Fallston, MD 21047</b>   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>  |  |
| 20c. Date<br><b>2/4/2008</b>   |  | 20d. Location - City or Town, State<br><b>Baltimore, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Steven H. Williams</b>   |  | 22. Name and Address of Facility<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Road, Baltimore, MD 21228</b>  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Atherosclerotic cardiovascular disease</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED<br><b>#23a, 27, per ME, g876, 2/14/08 TT</b> |  | Approximate Interval Between Onset and Death  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene    |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  |
| 28b. Time of Injury<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28c. Injury at Work?  |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><b>Pamela E. Southall, MD</b>  |  |
| 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 2, 2008</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02925

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Paul R. Dickhoff

2. Date of Death

Month Day Year  
01-25-2008

3. Time of Death

0223 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1008 Old Mountain Rd North

4b. City, Town, or Location of Death

Joppa

4c. County of Death

Harford

5. Social Security Number

215-28-4749

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
02-01-1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Joppa

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1008 Old Mountain Rd North

10f. Zip Code

21085

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Service Man

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

John Dickhoff

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Rosendale

19a. Informant's Name/Relationship (Type, Print)

Janet D. Dickhoff (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1008 Old Mountain Rd North Joppa, MD 21085

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parkwood Cemetery

Date

01-29-2008

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air  
Inc. 610 W. MacPhail Rd Bel Air, MD 2101423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. End Stage Liver Disease

Due to (or as a consequence of):

b. Cirrhosis

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ronald E. Thomas, MD 3455 Bay Hill Corp Center Drive, Abingdon, MD 21009

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DANIEL BERNARD DARRAH

2. Date of Death  
Month Day Year  
FEBRUARY 1 20083. Time of Death  
0914 MFuneral  
Director

4a. Facility Name (If not institution, give street and number)

CHESTER RIVER HOSPITAL CENTER

4b. City, Town, or Location of Death

CHESTER TOWN

4c. County of Death

KENT

5. Social Security Number

199-32-8138

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

8. Date of Birth (Month, Day, Year)

6-21-1940

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8043 Stone Haven Dr.

10f. Zip Code

21060

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Defense Worker

16b. Kind of Business/Industry

Department of Defense

17. Father's Name (First, Middle, Last)

Bernard Darrah

18. Mother's Name (First, Middle, Maiden Surname)

Helen Mary Darrah

19a. Informant's Name/Relationship (Type, Print)

Mrs. Angela Darrah/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8043 Stone Haven Dr.; Glen Burnie, MD 21060

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Cremation

Date

February 7,

20c. Location - City or Town, State

Stevensville, MD

21. Signature of Funeral Service Licensee

M01411

22. Name and Address of Facility

Singleton Funeral and Cremation  
1 2nd Ave. SW, Glen Burnie, MD 21061 Services23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. ASCVD  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. coronary artery disease  
Due to (or as a consequence of):

years

c. Diabetes  
Due to (or as a consequence of):

years

d.

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

00055720 MD

29d. Date signed (Month, Day, Year)

2/1/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah S. Davis MD CRHC 100 Rowan St. Chestertown MD 21620

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02927

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Henriette L. Eny

2. Date of Death

FEB 03 2008

3. Time of Death

12:45 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Bel Air Health and Rehabilitation Bel Air

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

105-16-9099

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

8. Date of Birth

July 6, 1920

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Joppa

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1030 Hollingsworth Road

10f. Zip Code

21085

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

At Home

17. Father's Name (First, Middle, Last)

Frank Herman

18. Mother's Name (First, Middle, Maiden Surname)

Marie Skalak

19a. Informant's Name/Relationship (Type, Print)

William Service -nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1725 Heatherwood Way-Sykesville, Maryland 21784

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

EVANS FUNERAL CHAPEL AND CREMATION SERVICES Bel Air

Date

Feb 4, 2008

20c. Location - City or Town, State

Forest Hill, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

EVANS FUNERAL CHAPEL AND CREMATION SERVICES

3 Newport Drive

Forest Hill, MD 21250

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Ovarian Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Heart Failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

H39022

29d. Date signed (Month, Day, Year)

February 4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1308 Business Center Way Edgewood MD 21040

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02928

Physician/  
Medical Examiner1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

MARIAH HOPE EDMISTEN

2. Date of Death  
Month Day Year  
January 28, 20083. Time of Death  
0345 hrs

4a. Facility Name (if not institution, give street and number)

University Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

218-79-9148

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

22 Days  
3 Months Yrs.

If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth (MM/DD/YYYY)

Oct. 6, 2007

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

613 Waterview Drive

10f. Zip Code

21226

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

None

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Clyde Allen Edmisten Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Alena Mariah Keith

19a. Informant's Name/Relationship (Type, Print)

Clyde Allen Edmisten Jr. (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

613 Waterview Drive, Baltimore, Maryland 21226

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory

Date

02-01-08

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully-Polyniak Funeral Home P.A.  
237 East Patapsco Avenue, Baltimore, Maryland

21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sudden infant death syndrome (SIDS)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED☐ AMENDED  
#23a, 27, per ME, g877, 3/5/08 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 29, 2008

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

OCME

Baltimore, MD 21215-0036  
11504  
To the Hospital or Attending Physician: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
Medical ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 2, 3, per me, g878, 04/07/08dhb

23a State of Maryland / Department of Health and Mental Hygiene  
1- For State Registrar Amend Item 25 per me, g877, 03/14/08dhb

2008 02929

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

State  
Registrar

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Cornelius Edmond</b>   |  | 2. Date of Death<br>Month <b>01</b> Day <b>29</b> Year <b>2008</b>   |  | 3. Time of Death<br><b>7:15 PM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>7610 Selmore Rd</b>  |  | 4b. City, Town, or Location of Death<br><b>Severna</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>  |  |
| 5. Social Security Number<br><b>218-26-9530</b>   |  | 6. Sex<br><b>1 Male 2 Female</b>   |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br><b>03/31/1929</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10. Inside City Limits<br><b>1 Yes 2 No</b>   |  |
| 10a. State<br><b>Md</b>   |  | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Severna</b>   |  |
| 10e. Street and Number<br><b>7610 Selmore Rd</b>  |  | 10f. Zip Code<br><b>21144</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No</b> |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>9th</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>                     |  | 16b. Kind of Business/Industry<br><b>Transportation</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Edmond</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Brittis Edmond</b>   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Betty Edmond/Wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7610 Selmore Rd, Severna, Md 21144</b>           |  |   |  |
| 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hedgecroft Memorial</b>   |  | 20c. Location - City or Town, State<br><b>Elkridge, Md</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>Turnell B. Cole, Sr.</b>  |  | 22. Name and Address of Facility<br><b>Open Funeral Services, 101 Elizabeth Ave, Baltimore, Md 21225</b>   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Coronary Artery Disease</b> |  | a. Due to (or as a consequence of):<br><b>Hypertension</b>   |  | Approximate Interval Between Onset and Death<br><b>10 years</b>   |  |
| b. Due to (or as a consequence of):   |  | c. Due to (or as a consequence of):  |  | d. Due to (or as a consequence of):   |  |
| 23b. Was decedent pregnant in the past 12 months?<br><b>1 Yes 2 No 9 Unknown</b>  |  | 23c. If yes, outcome of pregnancy<br><b>1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)</b>             |  | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>   |  |   |  |
| 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>   |  |   |  |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |   |  |
| 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><b>1 Yes 2 No</b>   |  | 28d. Describe how injury occurred  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>  |  | 29b. Signature and title of certifier<br><b>Erica Scavella</b>   |  |   |  |
| 29c. License number<br><b>D54734</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/1/2008</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Erica Scavella, MD, 800 Landmark Dr., Glen Burnie, MD</b>  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02930

1- For  
State  
Registrar

|  |  |                                 |   |  |   |   |   |  |
|--|--|---------------------------------|---|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>William J. Fugate Sr.</b>   |                                 |   |  | 2. Date of Death<br>Month Day Year<br><b>Feb 2, 2008</b>  |   | 3. Time of Death<br><b>4:05 PM</b>                                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Atlantic General Hospital</b>   |                                 |   |  | 4b. City, Town, or Location of Death<br><b>Berlin</b>   |   | 4c. County of Death<br><b>Worcester</b>                                 |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-30-5469</b>  | 6. Sex<br><b>1 M 2 F</b>        | 7. Age (in yrs. last birthday)<br><b>75</b> Yrs.  | If Under 1 Year<br>Months Days                   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Sept 29, 1932</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Baltimore, MD</b> |
|  | Usual Residence of Decedent  |                                 |   |  | 10c. City, Town or Location<br><b>Ocean City</b>  |   | 10d. Inside City Limits<br><b>1 Yes 2 No</b>                            |  |
| To Be Completed by<br>Funeral Director   | 10a. State<br><b>MD</b>  | 10b. County<br><b>Worcester</b> |   | 10e. Street and Number<br><b>501 94th Street</b> |   | 10f. Zip Code<br><b>21842</b>                               |   | 10g. Citizen of What Country?<br><b>USA</b>                      |
|  | 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>  |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No Specify:</b>  |   | 14. Race - American Indian, Black, White, etc.<br><b>Specify: white</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12 College (1-4 or 5+)</b>   |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner/Construction</b>    |  | 16b. Kind of Business/Industry<br><b>Fugate &amp; Sons</b>  |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Walter Fugate</b>  |                                 |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alice Armiger</b>   |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jean Fugate - spouse</b>  |                                 |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>501 94th Street Ocean City MD 21842</b> |   |   |  |
|  | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>  |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Cemetery</b>                                     |  | 20c. Location - City or Town, State<br><b>2-9-2008 Elkridge, Maryland</b>   |   |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Stacie Martin</b>  |                                 | 22. Name and Address of Facility<br><b>Evans Funeral Chapel &amp; Cremation Services - Parkville 8800 Harford Road Parkville MD 21234</b> |  |   |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Cerebro Vascular Accident</b>    |                                 |   |  |   |   |   |  |
|  | 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Aspiration pneumonia Cancer</b> |                                 |   |  |   |   |   |  |
|  | 23c. If yes, outcome of pregnancy<br><b>1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)</b>   |                                 |   |  |   |   |   |  |
| 23d. Date of delivery<br>Month Day Year  |  |                                 |   |  |   |   |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>   |  |                                 |   |  |   |   |   |  |
| 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>  |  |                                 |   |  |   |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>   |  |                                 |   |  |   |   |   |  |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>  |  |                                 |   |  |   |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |                                 |   |  |   |   |   |  |
| 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>                            |  |                                 |   |  |   |   |   |  |
| 28a. Date of Injury (Month, Day, Year)   |  |                                 |   |  |   |   |   |  |
| 28b. Time of Injury<br><b>M</b>  |  |                                 |   |  |   |   |   |  |
| 28c. Injury at Work?<br><b>1 Yes 2 No</b>  |  |                                 |   |  |   |   |   |  |
| 28d. Describe how injury occurred  |  |                                 |   |  |   |   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                                 |   |  |   |   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                                 |   |  |   |   |   |  |
| 29a. Certifier<br><b>1 Certifying Physician 2 Medical Examiner</b>   |  |                                 |   |  |   |   |   |  |
| 29b. Signature and title of certifier<br><b>John M. [Signature]</b>  |  |                                 |   |  |   |   |   |  |
| 29c. License number<br><b>064585</b>   |  |                                 |   |  |   |   |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>2-4-2008</b>   |  |                                 |   |  |   |   |   |  |
| 30. Name and address of person to whom cause of death (Item 23a) (Type, Print)<br><b>Anthony Beeth 9733 Heathway Drive Berlin MD 21811</b>           |  |                                 |   |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>  |  |                                 |   |  |   |   |   |  |
| 32. Registrar's Signature<br><b>[Signature]</b>  |  |                                 |   |  |   |   |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02931

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Mildred Frank

2. Date of Death

February 3, 2008

3. Time of Death

6:25 P M

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

217-01-5282

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

August 14, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

205 E. Joppa Road, #403

10f. Zip Code

21286

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Stenographer

16b. Kind of Business/Industry

Oil Company

17. Father's Name (First, Middle, Last)

George A. Frank

18. Mother's Name (First, Middle, Maiden Surname)

Mary L. Bayer

19a. Informant's Name/Relationship (Type. Print)

Charles J. Frank Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12310 Rosslare Ridge Road #402 Timonium, Maryland 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Most Holy Redeemer  
Cemetery

Date

2-7-2008

20c. Location - City or Town, State

Baltimore Maryland

21. Signature of Funeral Service Licensee

Paul Hagan

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.  
1050 York Road Towson, Maryland 2120423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebral artery disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Eddie Nakhuda

29c. License number

D15509

29d. Date signed (Month, Day, Year)

2-4-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

Eddie Nakhuda

FEBRUARY 3, 2008 6:25 p.m.  
Baltimore, Maryland 21215-0036permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural"; or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MARY FRANK

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02932

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Douglas Alfred Feldwick

2. Date of Death

February 3, 2008

3. Time of Death

2:30 a M

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

212-30-3509

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

May 10, 1914

9. Birthplace (State or Foreign Country)

England

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Phoenix

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9 Wetherbee Court

10f. Zip Code

21131

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrical Engineer

16b. Kind of Business/Industry

Bendix Corporation

17. Father's Name (First, Middle, Last)

Alfred

Feldwick

18. Mother's Name (First, Middle, Maiden Surname)

Florence

Thornton

19a. Informant's Name/Relationship (Type, Print)

Raymond D. Feldwick / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 Wetherbee Court Phoenix, Maryland 21131

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp. 2/5/08

Date

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

1050 York Road

Ruck Towson Funeral Home, Inc. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. EDDIE NAKHODA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

32. Registrar's Signature

FEB 05 2008

ORIGINAL

FEBRUARY 3, 2008 2:30 a.m.  
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DOUGLAS FELDICK  
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02933

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eleanor

Fields

2. Date of Death  
Month Day Year  
February 1 2008  
3. Time of Death  
0640 AM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

219-12-8397

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

Jan. 1, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

212 Parkwood Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Brockington

18. Mother's Name (First, Middle, Maiden Surname)

Theodosia Keen

19a. Informant's Name/Relationship (Type, Print)

Melvin Fields (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

212 Parkwood Road Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery

Date

2/6/2008

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Stroke

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury) that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
1 month

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES - 600

29d. Date signed (Month, Day, Year)

February 1, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Yolanda Chik 4940 Eastern Avenue Baltimore, MD 21224

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02934

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Betty Jane Ferber

2. Date of Death

February 1, 2008

3. Time of Death

8:30 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Good Samaritan Nursing Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

219-28-3174

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

03/31/1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5519 B Old National Pike

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Ford Motor Credit

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Mary Franz

19a. Informant's Name/Relationship (Type, Print)

Kirk Ferber - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5519 B Old National Pike Frederick, MD 21702

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

02/05/2008

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Road

Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number

D28987

29d. Date signed (Month, Day, Year)

2-4-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARL SPERLING, M.D. 5601 LOCH RAVEN BLVD BALTO MD 21239

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02935

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Massy Desmond ffrench-Mullen

2. Date of Death

January 31, 2008

3. Time of Death

11:25 PM

4a. Facility Name (If not institution, give street and number)

9601 Accord Drive

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

219-64-5083

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

8. Date of Birth

December 9, 1918

9. Birthplace (State or Foreign Country)

Jamaica

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9601 Accord Drive

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Agronomist

16b. Kind of Business/Industry

World Bank

17. Father's Name (First, Middle, Last)

Massy Onge Vincent ffrench-Mullen

18. Mother's Name (First, Middle, Maiden Surname)

Edith Dorothy Fox

19a. Informant's Name/Relationship (Type, Print)

Lory Walker ffrench-Mullen/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9601 Accord Drive, Potomac, Maryland 20854

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

February 3, 2008

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M01305

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Atrial Fibrillation

Due to (or as a consequence of):

c. Pulmonary Embolism

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic Prostate Cancer, Recurrent Plueral

Effusions, Anemia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D23170

29d. Date signed (Month, Day, Year)

February 1, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gita Bakshi, M.D. 9406 Old Georgetown Road, Bethesda, Maryland 20814

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02936

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Geraldine B. Gunn

2. Date of Death  
Month Day Year

FEB 03 2008

3. Time of Death

10:15 AM

4a. Facility Name (If not institution, give street and number)

ST AGNES HEALTH CARE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

220-74-5510

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb 9, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6348 Frederick Road

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Developmentally Disabled

16b. Kind of Business/Industry

Disabled

17. Father's Name (First, Middle, Last)

Cecil J. Gunn

18. Mother's Name (First, Middle, Maiden Surname)

Margaret E. Franz

19a. Informant's Name/Relationship (Type, Print)

Patricia A. Neville, Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2006 Royal Garden Drive Baltimore, Maryland 21207

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory Inc.

Date

02/04/08

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Thomas Gregor

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Road Baltimore, Maryland 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. BILATERAL PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MENTAL RETARDATION

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jyothi Punnam, MD

29c. License number

P19925

29d. Date signed (Month, Day, Year)

Feb, 03, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JYOTHI PUNNAM, 900 S. CATON AVENUE, BALTIMORE, MD 21229

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02937

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Charles Leonard Garey, Sr.

2. Date of Death  
Month Day Year  
February 2, 20083. Time of Death  
4:08 P M

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore Co.

5. Social Security Number  
213-07-28576. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
89 Yrs.8. Date of Birth (Month, Day, Year)  
July 7, 19189. Birthplace (State or Foreign Country)  
Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Baltimore10c. City, Town or Location  
Dundalk10d. Inside City Limits  
1 ☐ Yes 2 ☒ No10e. Street and Number  
1779 Brookview Road10f. Zip Code  
2122210g. Citizen of What Country?  
United States11. Marital Status  
1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)  
Elementary/Secondary (0-12) College (1-4or 5+)  
8 Years16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)  
Inspector16b. Kind of Business/Industry  
Steel Industry

17. Father's Name (First, Middle, Last)

Charles L. Garey

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle C. Krug

19a. Informant's Name/Relationship (Type, Print)

Douglas A. Garey (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2458 Chelmsford Drive Crofton, Maryland 21114

20a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)  
Parkwood CemeteryDate  
2/6/200820c. Location - City or Town, State  
Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 2122223a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Ischemic Cardiomyopathy  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death  
yearsSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury  
M28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number  
D 5830329d. Date signed (Month, Day, Year)  
February 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARND CHARRIS MD 6701 N. Charles St Towson MD 21204

31. Date filed (Month, Day, Year)  
FEB 05 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerDivision or Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02938

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Donald Irvin Gill

2. Date of Death  
Month Day Year  
January 29, 20083. Time of Death  
10:50P M

4a. Facility Name (If not institution, give street and number)

2805 Moorgate Road

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral  
Director5. Social Security Number  
220-22-46906. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
79 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
Nov. 9, 19289. Birthplace (State or Foreign Country)  
Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2805 Moorgate Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3 Years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

Thomas Gill

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice Reeves

19a. Informant's Name/Relationship (Type, Print)

Dorothy K. Gill (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2805 Moorgate Road Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Pleasant Grove United  
Methodist Church Cem.

Date

2/2/2008

20c. Location - City or Town, State

Reisterstown, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 2122223a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Coronary artery disease  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death  
yearsSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral vascular disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury  
M28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D42232

29d. Date signed (Month, Day, Year)

1/30/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scott Feeser 2112 Dundalk Ave, Baltimore, MD 21222

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02939

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ROBIN S. GILLIAM

2. Date of Death

Month Day Year  
JAN. 30, 2008

3. Time of Death

1: p M

4a. Facility Name (If not institution, give street and number)

127 S. CLINTON STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

219-66-5199

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
DEC. 15, 1958

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

127 S. CLINTON STREET

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10TH

College (1-4or 5+)

cook

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

ROBERT E. GILLIAM

18. Mother's Name (First, Middle, Maiden Surname)

SELENA REID

19a. Informant's Name/Relationship (Type, Print)

TASHA POOL (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

127 S. CLINTON ST. BALTO, MD. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

KING MEMORIAL PK. FEB. 7, 2008

BALTIMORE, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*Bernadine V. Scruggs*

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON ST. BALTO, MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

a. Hypoxic respiratory failure

Due to (or as a consequence of):

b. Metastatic non-small cell lung cancer

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate

Interval Between

Onset and Death

2 week

7 months

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]* MD

29c. License number

D0058593

29d. Date signed (Month, Day, Year)

January 31 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ilene S. Browner 4940 Eastern Ave Allt Baltimore, MD 21224

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02940

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MINNA

GOLDMAN

2. Date of Death  
Month Day Year  
JANUARY 28 20083. Time of Death  
5:25 P M

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

TAKOMA PARK

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

216-09-8798

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

03/27/1913

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12001 OLD COLUMBIA PIKE

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ISAAC

DEITZ

18. Mother's Name (First, Middle, Maiden Surname)

JENNIE

KOHN

19a. Informant's Name/Relationship (Type, Print)

JANE KATZ / NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

89 LAUREL PARK, NORTHAMPTON, MA 01060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BNAI ISRAEL CONG.

Date

01/31/2008

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Michael Kuzner

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRYTHMIA

Due to (or as a consequence of):

b. SEPSIS

Due to (or as a consequence of):

c. ACUTE RENAL FAILURE

Due to (or as a consequence of):

d. DEMENTIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Shamim, MD

29c. License number

D-59284

29d. Date signed (Month, Day, Year)

1/28/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAMIM SHAMIM, MD, WASHINGTON ADVENTIST HOSP, TAKOMA PARK, MD-20912

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02941

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LEON GREENBERG

2. Date of Death

Month Year Day  
FEBRUARY 2 2008

3. Time of Death

10:30 PM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

215-09-4168

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
08/12/1916

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

PIKESVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3800 OLD COURT ROAD

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

MUSICIAN

16b. Kind of Business/Industry

ENTERTAINMENT

17. Father's Name (First, Middle, Last)

REUBIN

GREENBERG

18. Mother's Name (First, Middle, Maiden Surname)

SARAH

PODLES

19a. Informant's Name/Relationship (Type, Print)

ANN KRESS / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4703 THREE OAKS RD., PIKESVILLE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

SHAAREI TFILOH CONG.

Date

02/04/2008

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one value on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DDA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0063430

29d. Date signed (Month, Day, Year)

FEBRUARY 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAVITEJ S. KHWAJA 5401 OLD COURT ROAD RANDALLSTOWN MD 21133

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2008 02942

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gwendoline M. Hambrick

2. Date of Death  
Month Day Year

Feb 1 2008

3. Time of Death

5:50 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

St Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

457-09-7416

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

8. Date of Birth (Month, Day, Year)

DEC 1 1918

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

108 Woodlawn Avenue

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Clerk

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Henry Bennett

18. Mother's Name (First, Middle, Maiden Surname)

Mamie Beckley

19a. Informant's Name/Relationship (Type, Print)

Joseph D. Hambrick, Jr. - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

108 Woodlawn Avenue, Catonsville, MD 21228

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 2/4/2008

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Steven H. Williams

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Road, Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. sepsis with pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 days

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. atrial fibrillation with RVR

Due to (or as a consequence of):

6 days

c. acute myocardial infarction

Due to (or as a consequence of):

4 days

d. gastrointestinal bleed

2 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D58571

29d. Date signed (Month, Day, Year)

Feb 1, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lynn Tao MD 900 Caton Avenue Baltimore Maryland

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Hambrick, Gwendolyn  
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02943

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Julie Ann Hensley

2. Date of Death

February 3 2008

3. Time of Death

7:37 p M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Gilchrist Center for Hospice Care

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

219-70-5310

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47 Yrs.

8. Date of Birth (Month, Day, Year)

FEB 27 1960

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

325 E. Timonium Road

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Dietary Aide

16b. Kind of Business/Industry

Healthcare

17. Father's Name (First, Middle, Last)

James Albert Robinson

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ellen Koons

19a. Informant's Name/Relationship (Type, Print)

Mary Ellen Robinson - mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

325 E. Timonium Road, Timonium, MD 21093

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc. 2/4/2008

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Steven H. Williams

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Road, Baltimore, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. metastatic adenocarcinoma of  
Due to (or as a consequence of):

uncertain primary site

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

months

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W.A. Riley, MD

29c. License number

125205

29d. Date signed (Month, Day, Year)

February 4, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley GMC 6701 N. Charles St. Balto. md 21204

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760, X

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02944

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Roger Hockett

2. Date of Death

January 31 2008

3. Time of Death

1119 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

219-30-8134

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

October 16, 1934

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4914 E. Federal Street

10f. Zip Code

21205

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Millwright

16b. Kind of Business/Industry

Can Company

17. Father's Name (First, Middle, Last)

Estel Hockett

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Clevenger

19a. Informant's Name/Relationship (Type, Print)

Geraldine Hockett/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4914 E. Federal Street Baltimore MD 21205

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gardens of Faith

Date

02/05/08

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

Brian C. Weller

22. Name and Address of Facility

Schimunek Funeral Home Inc.

9705 Belair Rd. Nottingham MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Anoxic Encephalopathy

Due to (or as a consequence of):

b. Cardiopulmonary Arrest

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Far days

Four days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Brian Silberman MD Medical Doctor

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

February 01, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Brian Silberman, 4940 Eastern Avenue, Baltimore, Maryland 21224

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

741



1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |   |  |   |  |   |  |  |  |                                   |  |  |
|--|---|--|---|--|---|--|--|--|-----------------------------------|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Ruth Hanley</b>                                    |  |   | 2. Date of Death<br>Month <b>Feb</b> Day <b>2</b> Year <b>08</b>   |   | 3. Time of Death<br><b>0119 AM</b>   |  |  |                                   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital</b> |  |   | 4b. City, Town, or Location of Death<br><b>Rosedale</b>  |   | 4c. County of Death<br><b>Baltimore</b>  |  |  |                                   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>442-42-1684</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>June 29, 1922</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |                                   |  |  |
|  | 10a. State<br><b>MD</b>   |  |   | 10b. County<br><b>Harford</b>  | 10c. City, Town or Location<br><b>Jarrettsville</b>   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |                                   |  |  |
| 10e. Street and Number<br><b>3976 Old Federal Hill Road</b>  |   |  | 10f. Zip Code<br><b>21084</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  |                                   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                            |  |                                   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |   | 16b. Kind of Business/Industry<br><b>At Home</b>   |  |  |                                   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles P. Breidenbaugh</b>  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rickie Koerner</b>   |   |  |  |  |                                   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jerilyn Rogers-daughter</b>   |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>289 North Fieldcrest Drive-Northeast, Maryland 21901</b> |   |  |  |  |                                   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bel Air Memorial Gardens</b>   |  | 20c. Location - City or Town, State<br><b>Feb. 5, 2008 Bel Air, Maryland</b>  |  |  |  |                                   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |  | 22. Name and Address of Facility<br><b>EVANS FUNERAL CHAPEL 3 Newport Drive AND CREMATION SERVICES Forest Hill, MD 21050</b>  |  |   |  |  |  |                                   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cardiogenic Shock</b><br>Due to (or as a consequence of):<br><b>b. Myocardial Infarction</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |  |   |  |   |  |  | Approximate Interval Between Onset and Death<br><b>18 hours</b><br><b>24 hours</b> |                                   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)                                       |  |   | 23d. Date of delivery<br>Month Day Year  |  |  |                                   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |                                   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |                                   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |                                   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  | 28d. Describe how injury occurred |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  | 29b. Signature and title of certifier<br><b>Jennifer K. Wormuth MD</b>  |  |   |  |  | 29c. License number<br><b>RES0000</b>  |                                   | 29d. Date signed (Month, Day, Year)<br><b>2/2/2008</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Jennifer K. Wormuth 9000 Franklin Square Drive Baltimore, MD 21237</b>  |   |  |   |  |   |  |  |  |                                   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>  |   |  | 32. Registrar's Signature<br>   |  |   |  |  |  |                                   |  |  |

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02946

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lucille F. Henkelmann

2. Date of Death

FEBRUARY 2, 2008

3. Time of Death

12:30AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

179-20-7072

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 1, 1928

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Lutherville

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

10 Weston Court

10f. Zip Code

21093

10g. Citizen of What Country?

United States

of America

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Residence

17. Father's Name (First, Middle, Last)

Harry N. Flavell Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Marie Deppen

19a. Informant's Name/Relationship (Type, Print)

Henry G. Henkelmann Jr./spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 Weston Court Lutherville, Maryland 21093

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Evans Funeral

Chapel - Bel Air

Date

February

3, 2008

20c. Location - City or Town, State

Forest Hill, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Peaceful Alternatives Funeral & Cremation Ctr., P.A.  
2325 York Road Timonium, Maryland 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ACUTE EXACERBATION CHRONIC OBSTRUCTIVE

Approximate Interval Between Onset and Death  
2 WEEKSDue to (or as a consequence of):  
PULMONARY DISEASE

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE MYOCARDIAL INFARCTION

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 26637

29d. Date signed (Month, Day, Year)

2/2/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARRY JOSEPHS, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, 3

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02947

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Herman

Hurt

2. Date of Death

Month

Day

Year

January 31 2008

3. Time of Death

22 54 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

5. Social Security Number

219-40-3734

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

12/04/1945

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2012 E. NORTH AVENUE

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11TH

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

STEEL WORKER

16b. Kind of Business/Industry

BETHLEHEM STEEL CORPORATION

17. Father's Name (First, Middle, Last)

HOWARD HURTT

18. Mother's Name (First, Middle, Maiden Surname)

GENEVA WILLIAMS

19a. Informant's Name/Relationship (Type, Print)

EVELYN HURTT / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2012 E. NORTH AVENUE, BALTIMORE, MD 21213

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

02/09/08

20c. Location - City or Town, State

CATONSVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HOWELL FUNERAL HOME 21207

4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

H0062638

29d. Date signed (Month, Day, Year)

2/4/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Rich 1600 W. Mount Royal Ave. Baltimore, MD 21217

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02948

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT K. HARNSBERGER, JR.

2. Date of Death

FEBRUARY 4 2008

3. Time of Death

12:30 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL  
3001 SOUTH HANOVER STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

220-24-9883

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 19, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1718 Patapsco Street

10f. Zip Code

21230

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Rod Mill Operator

16b. Kind of Business/Industry

Copper Refinery

17. Father's Name (First, Middle, Last)

Raymond

18. Mother's Name (First, Middle, Maiden Surname)

Harnsberger

Christina

Hildwein

19a. Informant's Name/Relationship (Type, Print)

Robert K. Harnsberger, Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

36 East Heath Street Baltimore, Maryland 21230

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

02/06/08

20c. Location - City or Town, State

Brooklyn Park, Maryland

21. Signature of Funeral Service Licensee

John F. Polyniak

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.A.  
130 East Fort Avenue Baltimore, Maryland 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ACUTE RESPIRATORY FAILURE SECONDARY TO  
CHRONIC OBSTRUCTIVE AIRWAY DISEASE EXACERBATION

Approximate Interval Between Onset and Death

10 DAYS

Due to (or as a consequence of):

ASTROCYTOMA.

3 WEEKS

Due to (or as a consequence of):

PNEUMONIA

10 DAYS

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Wayne M.D.

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

FEBRUARY 4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSITE IHEGWARA, 3001 S. HANOVER STREET, BALTIMORE, MARYLAND 21225

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

John F. Polyniak

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02949

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Marie Harris

2. Date of Death  
Month Day Year

January 31 2008

3. Time of Death

9:05 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Baltimore Washington Medical Center

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

232-68-9754

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64

8. Date of Birth  
(Month, Day, Year)

Aug. 23, 1943

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1033 A Bell Ave.

10f. Zip Code

21060

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12 Years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Crossing Guard

16b. Kind of Business/Industry

Baltimore County

17. Father's Name (First, Middle, Last)

Russel Heater

18. Mother's Name (First, Middle, Maiden Surname)

Audrey Martin

19a. Informant's Name/Relationship (Type, Print)

Jonathan Norwig, Jr. (Companion)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 957 Millersville, Maryland 21108

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hilltop Service Corp. 2/4/2008

Date

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

Heater, Russel

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiogenic Shock

Due to (or as a consequence of):

b. Acute Anterolateral ST Elevation Myocardial  
Infarction

Due to (or as a consequence of):

c. Left main thrombosis

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Shirley Marie Harris MD

29c. License number

D6418

29d. Date signed (Month, Day, Year)

1/31/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kelly Miller, M.D. 1417 Madison Park Drive Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

Harris, Shirley  
Baltimore, Maryland 21215-0036permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760, &lt;

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02950

1-

For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES S HERRING

2. Date of Death

Month

Day

Year

FEBRUARY

3

2008

3. Time of Death

12:35 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

212-76-1708

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

52

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Aug. 20, 1955

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

23 South Kresson Drive

10f. Zip Code

21224

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12 Years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Howard J. Herring

18. Mother's Name (First, Middle, Maiden Surname)

Cleta Harler

19a. Informant's Name/Relationship (Type, Print)

Mrs. Cleta Herring (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23 South Kresson Drive Baltimore, Maryland 21224

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Community Mem. Cem.

Date

2/8/2008

20c. Location - City or Town, State

Craigsville, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE UNKNOWN

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D62032

29d. Date signed (Month, Day, Year)

FEBRUARY 3, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JENNIFER HAYASHI 4940 EASTERN AVENUE BALTIMORE MD 21224

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, ✓

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02951

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Margaret M. Heinbuch

2. Date of Death  
Month Day Year  
February 3, 20083. Time of Death  
8:15 A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare

4b. City, Town, or Location of Death

Serverna Park

4c. County of Death

Anne Arundel

5. Social Security Number

212-10-6793

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 13, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6658 Shelly Road Apt 177

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James P. Clayton

18. Mother's Name (First, Middle, Maiden Surname)

Mary Bradley

19a. Informant's Name/Relationship (Type, Print)

Mr. Donald Heinbuch - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1333 Riverwood Way Curtis Bay, Maryland 21226

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

Feb. 7, 2008

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Paul L. Hartshorn Jr.

22. Name and Address of Facility

Baltimore, Maryland 21214  
Leonard J. Ruck, Inc. 5305 Harford Rd.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 WEEKS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Brian C. Wallace MD

29c. License number

D31136

29d. Date signed (Month, Day, Year)

FEBRUARY 3, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRIAN C. WALLACE MD, 9005 KILBRIDE RD, BALTIMORE, MD 21236

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, ✓

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2008 02952

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LAWRENCE E. HADDAWAY, SR.

2. Date of Death  
Month Day Year  
FEBRUARY 1, 20083. Time of Death  
11:15 A<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

FAIRFIELD NURSING CENTER

4b. City, Town, or Location of Death

CROWNSVILLE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

215-16-6948

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN. 24, 1916

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

MILLERSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

606 MILLWRIGHT CT. APT. 21

10f. Zip Code

21108

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
WHITE15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

MINISTER

16b. Kind of Business/Industry

CLERGY

17. Father's Name (First, Middle, Last)

LOUIS HADDAWAY

18. Mother's Name (First, Middle, Maiden Surname)

ESTELLE BROWN

19a. Informant's Name/Relationship (Type, Print)

JOYCE TSAO / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2004 BILOXI CIRCLE; PLANO, TX 75075

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MEADOWRIDGE MEM. PARK

Date

FEB. 4,

2008

20c. Location - City or Town, State

ELKRIDGE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

KIRKLEY-RUDDICK FUNERAL HOME, P.A.  
421 CRAIN HWY. SE; GLEN BURNIE, MD 2106123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

b. Cerebrovascular disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D38958

29d. Date signed (Month, Day, Year)

2/1/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daljeet Singh Sidhu 208 Crain Highway SW Glen Burnie MD 21061

31. Date filed (Month, Day, Year)

32. Registrar's Signature

FEB 05 2008

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, A

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008-02953

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LILY

HABER

2. Date of Death  
Month Day Year  
JANUARY 31 20083. Time of Death  
6:30 A MFuneral  
Director

4a. Facility Name (If not institution, give street and number)

HARMONY HALL ASSISTED LIVING

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

5. Social Security Number

068-38-1988

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97

8. Date of Birth (Month, Day, Year)

11/05/1910

9. Birthplace (State or Foreign Country)

AUSTRIA-HUNGARY

Usual Residence of Decedent

10a. State

MD

10b. County

HOWARD

10c. City, Town or Location

COLUMBIA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6336 CEDAR LANE, #326

10f. Zip Code

21044

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FRENCH TEACHER

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

SIMON

18. Mother's Name (First, Middle, Maiden Surname)

WEISS

YETTA

KAMERLING

19a. Informant's Name/Relationship (Type, Print)

ANNE SEILER / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5424 CHATTERBIRD PLACE, COLUMBIA, MD 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH DAVID CEMETERY

Date

02/03/2008

20c. Location - City or Town, State

ELMONT, NEW YORK

21. Signature of Funeral Service Licensee

Michael Sugar

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Pulmonary Hypertension

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

ASSISTED LIVING

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Abedat Ali Khan M.D.

29c. License number

D43323

29d. Date signed (Month, Day, Year)

January 31, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABEDAT ALI KHAN  
10820 Hickory Ridge Road Columbia MD 21044

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02954

1- For  
State  
Registrar

|  |  |  |   |  |  |  |
|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>John B. Imboden  |  | 2. Date of Death<br>Month: 2 Day: 3 Year: 2008  |  | 3. Time of Death<br>3:16 P.M.  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>111 West Lake Avenue   |  | 4b. City, Town, or Location of Death<br>Baltimore   |  | 4c. County of Death  |  |
| Funeral<br>Director  | 5. Social Security Number<br>212-36-0678   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>82 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>9/17/1925 | 9. Birthplace (State or Foreign Country)<br>Arkansas   |  |
|  | Usual Residence of Decedent  |  |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland   | 10b. County<br>Baltimore   | 10c. City, Town or Location<br>Baltimore  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|  | 10e. Street and Number<br>111 West Lake Avenue   |  | 10f. Zip Code<br>21210  |  | 10g. Citizen of What Country?<br>United States of America  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 5+  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Psychiatrist                             |  | 16b. Kind of Business/Industry<br>Psychiatry   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Clarence Imboden  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Landreth Baskerville   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Anne G. Imboden/ spouse  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>111 West Lake Avenue Baltimore, Maryland 21210       |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Evans Funeral Chapel- Bel Air   |  | 20c. Location - City or Town, State<br>Forest Hill, Maryland   |  |
|  | 21. Signature of Funeral Service Licensee<br>[Signature]   |  | 22. Name and Address of Facility<br>Peaceful Alternatives Funeral & Cremation Ctr., P.A.<br>2325 York Road Timonium, Maryland 21093                   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Acute myeloid leukemia<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):         |  |   |  |  |  |
|  | 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |   |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Pending investigation<br>3 <input type="checkbox"/> Accident 4 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined   |  |  |   |  |  |  |
| 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br>[Signature]<br>29c. License number<br>D30929<br>29d. Date signed (Month, Day, Year)<br>2/4/2008   |  |  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Paul Celano, MD 4565 N. Charles ST BALTIMORE MD 21204  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 05 2008<br>32. Registrar's Signature<br>[Signature]   |  |  |   |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02955

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Allen Paul Jones

2. Date of Death

January 29 2008

3. Time of Death

11:04 AM

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

214-44-8478

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

64

8. Date of Birth

Mar. 16, 1943

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Wood Bine

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

15025 Martlock Drive

10f. Zip Code

21797

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Maintenance Mechanic

16b. Kind of Business/Industry

Machine

17. Father's Name (First, Middle, Last)

John Paul Jones

18. Mother's Name (First, Middle, Maiden Surname)

Geraldine Alvera Guercio

19a. Informant's Name/Relationship (Type, Print)

Linda Martlock/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15025 Martlock Drive Wood Bine MD 21797

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

West Arundel Crematory

Date

2-4-2008

20c. Location - City or Town, State

Odenton, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ambrose Funeral Home of Lansdowne  
2719 Hammonds Ferry Rd. Lansdowne Md 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cholangiosarcoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

20 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Encephalopathy

Due to (or as a consequence of):

7 days

c. Pseudomonas bacteremia

Due to (or as a consequence of):

7 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)  
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage renal disease

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D54996

29d. Date signed (Month, Day, Year)

January 29 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bichhuong M. Dinh 400 S. Caton Ave, Baltimore, MD 21229

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02956

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Kenneth

Jackson

2. Date of Death

January 26, 2008

3. Time of Death

12:30 A M

4a. Facility Name (If not institution, give street and number)

Bradford Oaks Nursing Home

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

5. Social Security Number

228-28-6116

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

8. Date of Birth

July 28, 1928

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

VA

10b. County

10c. City, Town or Location

Fredericksburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11001 Ascot Circle

10f. Zip Code

22407

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Retired Machinest

16b. Kind of Business/Industry

Automobile

17. Father's Name (First, Middle, Last)

William Jackson

18. Mother's Name (First, Middle, Maiden Surname)

Edna May Willis

19a. Informant's Name/Relationship (Type, Print)

Selma C. Williams-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11001 Ascot Circle, Fredericksburg, VA 22407

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Good Hope Cemetery

Date

2-2-08

20c. Location - City or Town, State

Front Royal, VA

21. Signature of Funeral Service Licensee

*Therese Brundage*

22. Name and Address of Facility

Stover Funeral Home, Inc.  
177 North Holliday St., Strasburg, VA 22657

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Cancer of the prostate*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*months*

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D19431

29d. Date signed (Month, Day, Year)

1/28/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Franklin R. G. A. MD 11701 Livingston Rd #105 Ft. Washington MD 20744

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

*[Signature]*State  
Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

p.c.m. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02957

1- For  
State Amend #5, 20b, per FH, g876, 2/7/08 TT  
Registrar

## Certificate of Death

Reg. No.

|  |   |  |  |  |   |  |   |  |
|--|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Jessie Dorine Johnson</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>February 1, 2008</b>   |  | 3. Time of Death<br><b>12:52A M</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>7002 North Point Road</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Edgemere</b>   |  | 4c. County of Death<br><b>Baltimore Co.</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>238-46-2941</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                         |  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>May 22, 1933</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Edgemere</b>  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>7002 North Point Road</b>  |  | 10f. Zip Code<br><b>21219</b>   |  |
|  | 10g. Citizen of What Country?<br><b>United States</b>   |  |  |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
|  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b> <b>College (1-4or 5+)</b>                   |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Machine Operator</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Manufacturing</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>William Alonzo Johnson</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mae Burke</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kathy L. Bradley (Daughter)</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3012 Dunmore Road Dundalk, Maryland 21222</b>   |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b> |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>   |  | 20d. Date<br><b>2/4/2008</b><br><b>2/6/2008</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |  |  | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.</b><br><b>7922 Wise Ave. Dundalk, Maryland 21222</b>   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>End Stage Non Small Cell Lung Cancer</b><br>Due to (or as a consequence of):<br><b>Pulmonary Hypertension</b><br><b>Chronic Obstructive Pulmonary Disease</b><br><b>Failure to Thrive</b> |  |  |  | Approximate Interval Between Onset and Death<br><b>Yr.</b><br><b>Yr.</b><br><b>Years</b>  |  |   |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  |  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |   |  |
| 23d. Date of delivery<br>Month Day Year  |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |   |  |  | 28a. Date of Injury (Month, Day Year)<br><b>2/4/2008</b>   |   |  |   |  |
| 28b. Time of Injury<br><b>M</b>  |   |  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |
| 28d. Describe how injury occurred  |   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |
| 29b. Signature and title of certifier<br><b>Allen Reilly MD</b>  |   |  |  | 29c. License number<br><b>D54749</b>   |   |  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>2-1-2008</b>   |   |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Allen Reilly, MD 4 EAST Rolling Crossroads #307, Baltimore, Md</b>  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>  |   |  |  | 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |   |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02958

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Stephen F. Kraska

2. Date of Death  
Month Day Year  
01-29-20083. Time of Death  
1108 P MFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Upper Chesapeake Hospital

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

213-36-6422

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

8. Date of Birth (Month, Day, Year)

08-10-1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1001 Apt D Jessica's Ct

10f. Zip Code

21014

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Production Tech.

16b. Kind of Business/Industry

Lucent Technologies

17. Father's Name (First, Middle, Last)

Walter Kraska

18. Mother's Name (First, Middle, Maiden Surname)

Marie Arczynski

19a. Informant's Name/Relationship (Type, Print)

Leslie Klock (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1001 Apt D Jessica's Ct BEL Air, MD 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

Date

02-2-2008

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Diane G. Gao

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air  
Inc. 610 W. MacPhail Rd Bel Air, MD 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage of Renal Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dinglin Gao, MD

29c. License number

D0059855

29d. Date signed (Month, Day, Year)

Jan 30, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dinglin Gao, 500 Upper Chesapeake Dr. Bel Air, MD 21014

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02959

1- For  
State  
Registrar

|  |   |   |  |                                 |  |  |   |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
|--|---|---|--|---------------------------------|--|--|---|--|--|---|-------------------------------------|--|--|--------------------|---------------|------------------------------|---------------|-----------------------|---------------|--------------------------|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Tae Won Kim</b>  |   |  |                                 | 2. Date of Death<br>Month <b>2</b> Day <b>1</b> Year <b>2008</b>   |  |   | 3. Time of Death<br><b>6:30 P.<sup>M</sup></b>   |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Upper Chesapeake Medical Center</b>  |   |  |                                 | 4b. City, Town, or Location of Death<br><b>Bel Air</b>   |  |   | 4c. County of Death<br><b>Harford</b>  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-06-9723</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |                                 | 7. Age (In yrs. last birthday)<br><b>47</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>4/ 22/ 1960</b>         |  | 9. Birthplace (State or Foreign Country)<br><b>South Korea</b> |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
|  | Usual Residence of Decedent   |   |  |                                 |  |  |   |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Harford</b>  |                                 | 10c. City, Town or Location<br><b>Fallston</b>   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
|  | 10e. Street and Number<br><b>9 fallston View Court</b>  |   |  |                                 | 10f. Zip Code<br><b>21047</b>  |  | 10g. Citizen of What Country?<br><b>United States of America</b>  |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Korean</b>                       |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b>  |   |  |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>self employed</b>  |  |   | 16b. Kind of Business/Industry<br><b>food service</b>  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
|  | 17. Father's Name (First, Middle, Last)<br><b>Yoo Sung Kim</b>  |   |  |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Suk Eun Jung</b>   |  |   |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Soon Hyun Kim/ wife</b>  |   |  |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9 Fallston View Court Fallston, Maryland 21047</b>                                       |  |   |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>                 |                                 | Date<br><b>February 5, 2008</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b> |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
|  | 21. Signature of Funeral Service Licensee<br>   |   |  |                                 | 22. Name and Address of Facility<br><b>Peaceful Alternatives Funeral &amp; Cremation Ctr., P.A.<br/>2325 York Road Timonium, Maryland 21093</b>  |  |   |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |  |                                 |  |  |   |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
|  | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td><b>Brain Death</b></td> <td><b>40 hrs</b></td> </tr> <tr> <td><b>Anoxic Encephalopathy</b></td> <td><b>40 hrs</b></td> </tr> <tr> <td><b>Cardiac Arrest</b></td> <td><b>40 hrs</b></td> </tr> <tr> <td><b>Hemorrhagic Shock</b></td> <td><b>40 hrs</b></td> </tr> </table> |   |  |                                 |  |  |   |  |  | Immediate Cause (Final disease or condition resulting in death) | a. Due to (or as a consequence of): | Approximate Interval Between Onset and Death | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | <b>Brain Death</b> | <b>40 hrs</b> | <b>Anoxic Encephalopathy</b> | <b>40 hrs</b> | <b>Cardiac Arrest</b> | <b>40 hrs</b> | <b>Hemorrhagic Shock</b> |
| Immediate Cause (Final disease or condition resulting in death)  | a. Due to (or as a consequence of):   | Approximate Interval Between Onset and Death  |  |                                 |  |  |   |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | <b>Brain Death</b>  | <b>40 hrs</b>   |  |                                 |  |  |   |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
|  | <b>Anoxic Encephalopathy</b>  | <b>40 hrs</b>   |  |                                 |  |  |   |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
|  | <b>Cardiac Arrest</b>   | <b>40 hrs</b>   |  |                                 |  |  |   |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
|  | <b>Hemorrhagic Shock</b>  | <b>40 hrs</b>   |  |                                 |  |  |   |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |                                 |  | 23d. Date of delivery<br>Month Day Year  |   |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Ulcerated Gastric Artery</b>  |   |   |  |                                 |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                 |  |  |   |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                 |  |  |   |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b> |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |                                 |  |  |   |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>   |  |                                 | 29c. License number<br><b>D40819</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 1, 2008</b>    |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Marco Zamora, MD 500 Upper Chesapeake Drive, Bel Air, 21014</b>   |   |   |  |                                 |  |  |   |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>  |   | 32. Registrar's Signature<br>   |  |                                 |  |  |   |  |  |   |                                     |  |  |                    |               |                              |               |                       |               |                          |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02960

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward

Kellner

2. Date of Death  
Month Day Year  
2 1 20083. Time of Death  
7:00 P M

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

212-10-2043

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93

8. Date of Birth (Month, Day, Year)

1-26-1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Sparks

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15 Rainflower Path #103

10f. Zip Code

21152

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Vice President - National Sales A/B Brewery

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Albert

C.

Kellner

18. Mother's Name (First, Middle, Maiden Surname)

Sadie

B.

Busch

19a. Informant's Name/Relationship (Type, Print)

Barbara

Kellner

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as #10a - #10f

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oaklawn

Date

2/5/08

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Ernest L. Feist, III

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.  
1050 York Rd, Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Eddie Nakhuda, M.D.

29c. License number

D 15504

29d. Date signed (Month, Day, Year)

2 4 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

Eddie Nakhuda

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02961

1- For State Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner

Funeral Director

|  |  |   |  |  |
|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Audrey L. Kelley</b>  |  | 2. Date of Death<br>Month Day Year<br><b>January 26, 2008</b>   |  | 3. Time of Death<br><b>9:15 P<sup>M</sup></b>  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Wilson Health Care</b>  |  | 4b. City, Town, or Location of Death<br><b>Gaithersburg</b>   |  | 4c. County of Death<br><b>Montgomery</b>   |
| 5. Social Security Number<br><b>235-44-6764</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 6, 1930</b> | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>   |
| Usual Residence of Decedent  |  |   |  |  |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Montgomery</b>   | 10c. City, Town or Location<br><b>Silver Spring</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| 10e. Street and Number<br><b>9208 Columbia Blvd.</b>   |  | 10f. Zip Code<br><b>20877</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Edward Layne</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth Moore</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Stephen Kelley (Son)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9208 Columbia Blvd., Silver Spring, MD 20877</b>  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Elk Hills Memorial Park</b>  |  | 20c. Location - City or Town, State<br><b>Charleston, WV</b>   |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Hafer Funeral Home<br/>50 N. Pinch Rd., Elkview, WV 25071</b>  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Adult failure to thrive</b><br>Due to (or as a consequence of):<br><b>Metastatic breast carcinoma</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Diabetes (insulin) Hypertension Esophagitis. Renal insufficiency. Chronic disease</b> |  |   |  | Approximate Interval Between Onset and Death<br><b>9 months</b>  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)                                       |  | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes (insulin) Hypertension Esophagitis. Renal insufficiency. Chronic disease</b>   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>204115</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>January 27, 2008</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>N. ROBERT BIRSCHBACH, M.D. 201 RUSSELL AVENUE GAITHERSBURG, MD 20877</b>  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>  |  | 32. Registrar's Signature<br>   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Jennifer Ballard Koch

|   |   |  |  |  |  |
|---|---|--|--|--|--|
| 1- For State Registrar                        |   | Reg. No.   |  |  |  |
| Physician/<br>Medical Examiner                | 1. Decedent's Name (First, Middle, Last)<br>Jennifer Ballard Koch   |  | 2. Date of Death<br>Month Day Year<br>January 29, 2008   | 3. Time of Death<br>1433 hrs                   |  |
|   | 4a. Facility Name (if not institution, give street and number)<br>Route 15 at Route 464   |  | 4b. City, Town, or Location of Death<br>Point of Rocks   | 4c. County of Death<br>Frederick               |  |
| Funeral<br>Director                           | 5. Social Security Number<br>192-46-6519  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>47 Yrs.  | 8. Date of Birth (MM/DD/YYYY)<br>July 31, 1960 | 9. Birthplace (State or Foreign)<br>Pennsylvania   |
|   | Usual Residence of Decedent   |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br>Virginia  | 10b. County<br>Loudoun   | 10c. City, Town or Location<br>Haymarket   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br>15056 Doral Place   |  | 10f. Zip Code<br>20169   | 10g. Citizen of What Country?<br>U.S.A.        |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4  |  |  |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Sales Manager  |  | 16b. Kind of Business/Industry<br>Pharmaceutical Co.   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Ian Matheson Ballard   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Paula Staples   |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Henry T. Koch (Husband)   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>15056 Doral Pl., Haymarket, VA 20169  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory   |  | 20c. Location - City or Town, State<br>1-31-08 Alexandria, VA  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>Dennis P. Williams</i>  |  | 22. Name and Address of Facility<br>Royston Funeral Home<br>P.O. Box 163 Middleburg, VA 20118  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Immediate Cause (Final disease or condition resulting in death)<br>a. Multiple Injuries<br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.   |  |  |  |  |
|   | Approximate Interval Between Onset and Death  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown  |  |  |  |  |
|   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23d. Date of delivery<br>Month Day Year   |  |  |  |  |
|   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene    |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide               |  | 28a. Date of Injury (Month, Day, Year)<br>Jan 29, 2008   |  |  |
|   | 28b. Time of Injury<br>1420 hrs   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred<br>Subject driver of vehicle in vehicular accident  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify) Major Road / Highway   |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Route 15 at Route 464, Point of Rocks, MD   |  | 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><i>Theodore M. King, Jr., MD.</i>  |  | 29c. License number<br>OCME<br>O.C.M.E.  |  | 29d. Date signed (Month, Day, Year)<br>January 30, 2008  |
|   | 30. Name and address of person who completed cause of death (Item 23a)<br>Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>FEB 05 2008  |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02963

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

THERESA CHRISTINE KRAMER

2. Date of Death

January 30, 2008

3. Time of Death

2:33P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

GILCHRIST CENTER OF BALTO. HOSPICE

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore County

5. Social Security Number

074-18-0537

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

8. Date of Birth (Month, Day, Year)

May 22, 1925

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore County

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2300 Dulaney Valley Road

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Medical Services

17. Father's Name (First, Middle, Last)

Bronislaw (Benjamin)

Zemak

18. Mother's Name (First, Middle, Maiden Surname)

Alexandra

Kagznaczyk

19a. Informant's Name/Relationship (Type, Print)

Pricscilla Connolly (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11412 Mays Chapel Road, Timonium, Maryland 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial Gardens

Date

Feb 2, 2008

20c. Location - City or Town, State

Timonium, Maryland

21. Signature of Funeral Service Licensee

Martin D. Lawson

22. Name and Address of Facility

MITCHELL-WIEDEFELD FUNERAL HOME, INC.  
6500 York Road, Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PARKINSONS DISEASE

Due to (or as a consequence of):

YEARS

c. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 64395

29d. Date signed (Month, Day, Year)

JANUARY 30, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIELLE DOBERMAN, MD 6565 N. CHARLES ST. SUITE 209 BALTIMORE, MD 21204

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

Certificate of Death

Reg. No.

2008 02964

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Lakita Kellam

2. Date of Death  
Month Day Year  
February 2 2008  
3. Time of Death  
21:05 M

Funeral Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

219 88 8355

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

32 Yrs.

8. Date of Birth (Month, Day, Year)

JULY 24, 1975

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

518 ROBERTSON ST.

10f. Zip Code

21205

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NURSING ASSISTANT

16b. Kind of Business/Industry

PRIVATE DUTY

17. Father's Name (First, Middle, Last)

CHARLES RANSON

18. Mother's Name (First, Middle, Maiden Surname)

GLORIA KELLAM

19a. Informant's Name/Relationship (Type. Print)

GLORIA KELLAM (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

518 ROBERTSON ST. BALTO, MD. 21205

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION TRINITY CEM.

Date

FEB. 12, 2008

20c. Location - City or Town, State

BALTO, MD.

21. Signature of Funeral Service Licensee

Bernadine J. Scruggs

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME  
1412 F. PRESTON ST. BALTO, MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Mycobacterium Aivum Complex Infection

Due to (or as a consequence of):

b. Human Immunodeficiency Virus

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death  
9 months  
10 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Marisha Cook, MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

February 4, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marisha Cook 4440 Eastern Avenue, Baltimore, MD. 21224

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02965

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Katharine M. Lemmerman

2. Date of Death

February 2 2008

3. Time of Death

2:14 a M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Gilchrist Center for Hospice Care

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

219-36-2007

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

8. Date of Birth (Month, Day, Year)

MAY 17 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

119 Stonewall Road

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Albert Hobson

18. Mother's Name (First, Middle, Maiden Surname)

Madalene Phiffer

19a. Informant's Name/Relationship (Type, Print)

Linda Lemmerman - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

140 Longview Drive, Catonsville, MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

2/6/2008

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Steven H. Williams

22. Name and Address of Facility

MacNabb Funeral Home, P.A.

301 Frederick Road, Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Katharine M. Lemmerman

29c. License number

D58303

29d. Date signed (Month, Day, Year)

February 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARON J. CHARLES MD 6701 W. Charles St Towson MD 21204

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

Katharine M. Lemmerman

State Registrar

10

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Katharine M. Lemmerman 2/6/08 0214 Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02966

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Pamela Lou Leake

2. Date of Death

January 31, 2008

3. Time of Death

1131 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

St. Agnes Health Care

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

216-78-6009

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

47

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

Apr. 10, 1960

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2000 Deering Avenue

10f. Zip Code

21230

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Robert Lee Kendall, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Thelma Mae Miller

19a. Informant's Name/Relationship (Type, Print)

Kevin Leake - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2000 Deering Avenue, Baltimore, MD 21230

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park

Date

2-4-2008

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ambrose Funeral Home, Inc.

1328 Sulphur Spring Rd., Arbutus, MD 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 minute

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Respiratory Arrest

Due to (or as a consequence of):

30 minutes

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No☐ Yes ☐ No ☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown

3. Ectopic pregnancy

5. Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Diabetes

Sleep Apnea

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

BC9916295

29d. Date signed (Month, Day, Year)

January 31, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Meghan Chuckley

900 South Caton Avenue

Baltimore, Maryland

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Leake, Pamela L.

49

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02967

Physician/  
Medical Examiner1- For State  
Registrar

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Benjamin Lewis Lyons</b>  |  | 2. Date of Death<br>Month Day Year<br><b>January 30, 2008</b>   |  | 3. Time of Death<br><b>0650 hrs</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>1231 Fidler Lane</b>  |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |  | 4c. County of Death<br><b>Montgomery</b>  |  |
| 5. Social Security Number<br><b>472-11-3948</b>  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>30</b> Yrs.  |  |
| 8. Date of Birth (MM/DD/YYYY)<br><b>Oct 9, 1977</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MN</b>   |  |   |  |
| Usual Residence of Decedent  |  |   |  |   |  |
| 10a. State<br><b>ND</b>  |  | 10b. County<br><b>Cass</b>  |  | 10c. City, Town or Location<br><b>Fargo</b>   |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |   |  |
| 10e. Street and Number<br><b>1002 43 1/2 Street South</b>  |  | 10f. Zip Code<br><b>58103</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Retail Sales</b>  |  | 16b. Kind of Business/Industry<br><b>Stocker</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Fred Lyons</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Arlene Amundson</b>   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Fred Lyons - Father</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11391 Navajo Circle Unit C Westminster, CO 80234</b>  |  |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Brookfield Crematory</b>   |  | 20c. Location - City or Town, State<br><b>Brookfield, Colorado</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>Shen Beendle</i>   |  | 22. Name and Address of Facility<br><b>Rundus Funeral Home</b><br><b>1998 W. 10th Ave. Broomfield, CO 80020</b>   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |
| Immediate Cause (Final disease or condition resulting in death)  |  | a. Hanging<br>Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | b. Due to (or as a consequence of):   |  |   |  |
|  |  | c. Due to (or as a consequence of):   |  |   |  |
|  |  | d. Due to (or as a consequence of):   |  |   |  |
| <input type="checkbox"/> UNPENDED  |  | <input type="checkbox"/> AMENDED  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>6 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene    |  |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br><b>FOUND: Jan 30, 2008</b>  |  | 28b. Time of Injury<br><b>FOUND: 0615 hrs</b>   |  |
| 28c. Injury at Work?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>Subject hanged self</b>   |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Other (const. site)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>1231 Fidler Lane, Silver Spring, MD</b>  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |
| 29b. Signature and title of certifier<br><i>Tasha Greenberg MD</i>   |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>January 30, 2008</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- <sup>For State Registrar</sup> **amend #23e Per FH G876 2/21/08** **State of Death**Reg. No. **2008 02968**Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |  |  |  |   |  |   |  |  |  |
|---|--|---|--|--|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Theodore Michael Lapka</b>   |  |   |  | 2. Date of Death<br>Month <b>January</b> Day <b>28</b> Year <b>2008</b>  |  |   |  | 3. Time of Death<br><b>7:45 P<sup>M</sup></b>                           |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>609 South Oldham Street</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>  |  |   |  | 4c. County of Death<br><b>N/A</b>                                       |  |  |  |
| 5. Social Security Number<br><b>216-24-9707</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 29, 1929</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>             |  |  |  |
| 10a. State<br><b>Maryland</b>   |  |   |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore City</b>        |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>609 South Oldham Street</b>  |  |   |  | 10f. Zip Code<br><b>21224</b>  |  |   |  | 10g. Citizen of What Country?<br><b>United States</b>                   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Years</b> College (1-4or 5+) <b>College</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Forklift Operator</b>  |  |   |  | 16b. Kind of Business/Industry<br><b>Warehousing</b>                    |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Theodore Lapka</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Cecelia Fialkowska</b>   |  |   |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Charlotte Lapka (Wife)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>609 South Oldham Street Baltimore, Maryland 21224</b>                                    |  |   |  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holly Hill Mem. Gdns. 2/1/2008</b>  |  |   |  | 20c. Location - City or Town, State<br><b>Middle River, MD</b>          |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>  |  |   |  |   |  |  |  |

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. Malignant fibrous histiocytoma</b><br>Due to (or as a consequence of):  |  |   |  | Approximate Interval Between Onset and Death<br><b>2 years</b> |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b>   |  |   |  |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>                                |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|  |  | 28d. Describe how injury occurred   |  |  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>RES000</b>                           |  | 29d. Date signed (Month, Day, Year)<br><b>01/29/2008</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Amy Kimball MD, Baltimore VA, 10 N Greene St, Baltimore MD 21201</b>  |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>  |  | 32. Registrar's Signature<br>   |  |  |  |   |  |

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02969

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Thomas LeFave

2. Date of Death

Month Day Year  
February 1, 2008

3. Time of Death

4:15 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

8200 Wisconsin Avenue, #611

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

030-32-1247

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
December 27, 1943

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8200 Wisconsin Avenue, #611

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1964-1970

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Nuclear Engineer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Walter LeFave

18. Mother's Name (First, Middle, Maiden Surname)

Ruth McIsaac

19a. Informant's Name/Relationship (Type, Print)

Stephanie D. LeFave / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8200 Wisconsin Avenue, #611, Bethesda, Maryland 20814

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Quantico National Cemetery

Date

February 12, 2008

20c. Location - City or Town, State

Triangle, Virginia

21. Signature of Funeral Service Licensee

M01305

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

a. Coronary Heart Disease

Due to (or as a consequence of):

b. Atherosclerosis

Due to (or as a consequence of):

c. Multiple Risk Factors

Due to (or as a consequence of):

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Type II Diabetes, High Cholesterol

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0014364

29d. Date signed (Month, Day, Year)

February 4, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohammad H. Chaudhry, M.D. 7610 Carroll Avenue, Takoma Park, Maryland 20912

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #8, per FH, 876, 2/5/08 TT Certificate of Death

Reg. No. 2008 02970

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Jasmine Little</b>   |  | 2. Date of Death<br>Month <b>January</b> Day <b>31</b> Year <b>2008</b>  |   | 3. Time of Death<br><b>1:59 AM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>The Johns Hopkins Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |   | 4c. County of Death<br><b>N/A</b>  |  |
| 5. Social Security Number<br><b>215 43 4507</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>13</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 10, 1994</b> | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  |
| 10a. State<br><b>MD.</b>  |  | 10b. County<br><b>N/A</b>  |   | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>7116 MINNA ROAD</b>   |   | 10f. Zip Code<br><b>21207</b>  |  |
| 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7TH</b> College (1-4or 5+)   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>STUDENT</b>   |  | 16b. Kind of Business/Industry<br><b>BENNETT MIDDLE SCHOOL</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>RODNEY LITTLE (father)</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Tia Mc Carthy</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>RODNEY LITTLE (father)</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>916 GORSUCH AVE. BALTIMORE 21218</b>   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>LORRAINE PARK</b>   |   | 20c. Location - City or Town, State<br><b>Feb. 7, 2008 BALTIMORE, MD.</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>Bernadine V. Krueger</i>  |  | 22. Name and Address of Facility<br><b>CALVIN B. SCRUGGS FUNERAL HOME<br/>1412 E. PRESTON ST. BALTO, MD. 21213</b>   |   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Renal cell carcinoma</b><br>Due to (or as a consequence of):<br>b. <b>Renal failure</b><br>Due to (or as a consequence of):<br>c. <b>metastatic pleural effusions</b><br>Due to (or as a consequence of):<br>d. |  | Approximate Interval Between Onset and Death<br><b>2 months</b><br><b>2 weeks</b><br><b>2 months</b>   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br>9 Unknown   |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |
| 29b. Signature and title of certifier<br><i>Carolyn Feltz MD</i>  |  | 29c. License number<br><b>Res-000</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>January 31, 2008</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Carolyn Feltz MD 600 North Wolfe Street Baltimore Maryland 21287</b>   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |  |

|   |  |  |  |  |
|---|--|--|--|--|
| Physician/<br>Medical Examiner                | 1- For State Registrar   |  | Reg. No.   |  |
|   | 1. Decedent's Name (First, Middle, Last)<br>Ellery George Mickel   |  | 2. Date of Death<br>Month Day Year<br>February 1, 2008   |  |
| Funeral Director                              | 4a. Facility Name (if not institution, give street and number)<br>204 Red Lion Branch Road   |  | 4b. City, Town, or Location of Death<br>Millington   |  |
|   | 4c. County of Death<br>Queen Anne's  |  |  |  |
| To Be Completed by Funeral Director           | 5. Social Security Number<br>212-92-5774   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>42 Yrs.  | 8. Date of Birth (MM/DD/YYYY)<br>July 17, 1965 |
|   | 9. Birthplace (State or Foreign Country)<br>Kansas   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 10a. State<br>Maryland   |  | 10b. County<br>Baltimore   |  |
|   | 10c. City, Town or Location<br>Halethorpe  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 10e. Street and Number<br>203 4th Avenue   |  | 10f. Zip Code<br>21227   |  |
|   | 10g. Citizen of What Country?<br>USA   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Carpenter   |  |
|   | 16b. Kind of Business/Industry<br>Warehouse  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>Howard A. Mickel  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Frances L. Giffin   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Evan Mickel, Brother   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4 Broadridge Lane Lutherville, Maryland 21093   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory Inc.   |  |
|   | 20c. Location - City or Town, State<br>Baltimore, Maryland   |  | 20d. Date<br>02/04/08  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>Thomas Gregor   |  | 22. Name and Address of Facility<br>Cremation Society of Maryland, Inc.<br>299 Frederick Road Baltimore, Maryland 21228  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Cardiomegaly</u><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED<br>#23a, 27, per ME, g877 3/10/08 TT |  | Approximate Interval Between Onset and Death   |  |
| To Be Completed by Physician/Medical Examiner | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown  |  |
|   | 23d. Date of delivery<br>Month Day Year  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |
|   | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene   |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br>28b. Time of Injury<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>Margarita Korell MD. Assistant Medical Examiner   |  |
|   | 29c. License number<br>O.C.M.E.  |  | 29d. Date signed (Month, Day, Year)<br>February 2, 2008  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a)<br>Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>FEB 05 2008   |  | 32. Registrar's Signature<br>[Signature]   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02972

1- For State Registrar

Certificate of Death

Reg. No.

|  |   |  |   |   |   |
|--|---|--|---|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>HARRY MARTINDALE</b>   |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>2</b> Year <b>2008</b>   |   | 3. Time of Death<br><b>6:00 AM</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Glen Burnie Health &amp; Rehabilitation</b>  |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>  |   | 4c. County of Death<br><b>Anne Arundel</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-03-1574</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>JAN 18 1921</b>                                   |   |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |   |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Anne Arundel</b>  |   | 10c. City, Town or Location<br><b>Glen Burnie</b>   |
|  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |   |
|  | 10e. Street and Number<br><b>7355 Furnace Branch Road</b>   |  | 10f. Zip Code<br><b>21061</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |   |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Factory Worker</b>                  |   | 16b. Kind of Business/Industry<br><b>Aluminum</b>   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Edgar Allen Martindale</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Elizabeth Pike</b>   |   |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Audrey M. Martindale - daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1833 S. Charles Street, Baltimore, MD 21230</b> |   |   |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>  |   | Date<br><b>2/4/2008</b>   |
|  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>   |  |   |   |   |
| 21. Signature of Funeral Service<br><b>Steven H. Williams</b>  |   | 22. Name and Address of Facility<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Road, Baltimore, MD 21228</b> |   |   |   |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ASPIRATION PNEUMONIA</b>                                      |  |   |   | Approximate Interval Between Onset and Death<br><b>1 DAY</b>  |
|  | 23b. Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>CEREBROVASCULAR DISEASE</b>  |  |   |   | <b>3 YEARS</b>  |
|  | 23c. Due to (or as a consequence of):<br><b>GENERALIZED ARTERIOSCLEROSIS</b>  |  |   |   | <b>15 YEARS</b>   |
|  | 23d. Due to (or as a consequence of):   |  |   |   |   |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  |   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)                                     |
|  | 23d. Date of delivery<br>Month Day Year   |  |   |   |   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>- CORONARY ARTERY DISEASE</b><br><b>- COLON CANCER</b><br><b>DEMENCIA</b>  |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |  |   |   | 28a. Date of Injury (Month, Day Year)<br><b></b>  |
| 28b. Time of Injury<br><b>M</b>  |   |  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 28d. Describe how injury occurred  |   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)      |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |   |   |
| 29b. Signature and title of certifier<br><b>R. Leisley M.D.</b>  |   |  |   | 29c. License number<br><b>D-22609</b>   |   |
| 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 2-2008</b>  |   |  |   |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RUBEN REIDER M.D. 7445 FURNACE BRANCH RD GLEN BURNIE MD 21060</b>   |   |  |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>  |   |  |   | 32. Registrar's Signature<br><b>[Signature]</b>   |   |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No.

2008 02973

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES

MILLER

2. Date of Death

Month Day Year  
FEBRUARY 2 2008

3. Time of Death

4:10 A M

4a. Facility Name (If not institution, give street and number)

MANORCARE

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

146-20-0941

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
5/27/26

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1257 Halstead Road

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4or 5+)

12 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Physical Therapist

16b. Kind of Business/Industry

Johns Hopkins

17. Father's Name (First, Middle, Last)

Andrew W. Case

18. Mother's Name (First, Middle, Maiden Surname)

Sara Dietz

19a. Informant's Name/Relationship (Type, Print)

Harry D. Miller, Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1257 Halstead Rd. Parkville, MD 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dolany Valley Mem. Gardens

Date

2/7/08

20c. Location - City or Town, State

Timonium, MD

21. Signature of Funeral Service Licensee

Kimberly D. Zalesky

22. Name and Address of Facility

8800 Harford Rd. Baltimore, MD 21234

Evans Funeral Chapel - Cremation Services Parkville

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

DS7722

29d. Date signed (Month, Day, Year)

FEBRUARY 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEONARD RICHARDSON M.D. 1838 GREENE TREE ROAD #300 PIKEVILLE, MD 21208

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02974

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |  |  |  |                                |  |  |
|---|--|--|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Emmett Francis McGee, Sr.</b>  |  |  |  | 2. Date of Death<br>Month <b>February</b> Day <b>3</b> Year <b>2008</b>  |                                | 3. Time of Death<br><b>12:15 p m</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Stella Maris</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Timonium</b>  |                                | 4c. County of Death<br><b>Baltimore</b>  |  |
| 5. Social Security Number<br><b>213-34-5860</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>Feb 25, 1936</b>                                     |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |  |                                |  |  |
| Usual Residence of Decedent   |  |  |  |  |                                |  |  |
| 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Towson</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>205 E. Joppa Rd. Unit 1404</b>   |  |  |  | 10f. Zip Code<br><b>21286</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>+1</b>  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Broker</b>   |                                | 16b. Kind of Business/Industry<br><b>Insurance</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Emmett A. McGee</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eleanor Flynn</b>  |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Timothy McGee/ Son</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2904 York Manor Rd. Phoenix, Md. 21131</b>   |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Cross Cemetery</b>   |  | Date<br><b>2-9-08</b>  |                                | 20c. Location - City or Town, State<br><b>Baltimore, Md.</b>                                   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, Md. 21204</b>  |                                |  |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Malignant Mesothelioma</b>   |  |  |  |  |                                |  |  |
| 23b. Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |  |  |  |                                |  |  |
| a. Due to (or as a consequence of):   |  |  |  |  |                                |  |  |
| b. Due to (or as a consequence of):   |  |  |  |  |                                |  |  |
| c. Due to (or as a consequence of):   |  |  |  |  |                                |  |  |
| d. Due to (or as a consequence of):   |  |  |  |  |                                |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  |  |  |  |  |                                |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)   |  |  |  |  |                                |  |  |
| 23d. Date of delivery<br>Month Day Year   |  |  |  |  |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |                                |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |  |  |                                |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |                                |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |  |                                |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |  |  |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  |
| 28d. Describe how injury occurred   |  |  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |                                |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |                                |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |  |                                |  |  |
| 29b. Signature and title of certifier<br>   |  |  |  | 29c. License number<br><b>714504</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>2-9-08</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>   |  |  |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>   |  |  |  | 32. Registrar's Signature<br>  |                                |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02975

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN A. MENGEL

2. Date of Death

Month Day Year  
Feb. 3, 2008

3. Time of Death

10:28 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

645 Piccadilly Road

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

216-12-2391

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Apr. 9, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

645 Piccadilly Road

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Mechanical Engineer

16b. Kind of Business/Industry

Martin Marietta

17. Father's Name (First, Middle, Last)

John A. Mengel, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Thompson

19a. Informant's Name/Relationship (Type, Print)

Mrs. beatrice Mengel/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

645 Piccadilly Road Towson, Maryland 21204

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Dulaney Valley Mem. Grd. 2/8/08 Timonium, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.  
1050 York Road Towson, Maryland 2120423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Pneumonia  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

2 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Dysphagia  
Due to (or as a consequence of):

2 years

c. Alzheimer's disease  
Due to (or as a consequence of):

5 years

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D25569

29d. Date signed (Month, Day, Year)

2/4/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Francis Wiegmann, M.D. / 1205 York Rd., #11 / Lutherville, Md. 21093

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02976

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Gordon Edward Miles, Sr.

2. Date of Death  
Month Day Year

February 1, 2008

3. Time of Death  
M

6:01am

4a. Facility Name (If not institution, give street and number)

Manor Care Ruxton

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

214-14-8122

6. Sex  
M ☒ F ☐

7. Age (In yrs. last birthday)

86

8. Date of Birth (Month, Day, Year)

Dec. 13, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Rosedale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6608 Kenwood Ave.

10f. Zip Code

21237

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8 years

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Forklift Operator

16b. Kind of Business/Industry

Bell Systems

17. Father's Name (First, Middle, Last)

Robert Miles

18. Mother's Name (First, Middle, Maiden Surname)

Addie Spurry

19a. Informant's Name/Relationship (Type, Print)

Joan M. Sullivan (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

105 Skyview Drive Shewsbury, PA 17361

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

2-5-2008

20c. Location - City or Town, State

Brooklyn Park, MD

21. Signature of Funeral Service Licensee

J. Wayne Osterling

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.A.  
237 E. Patapsco Ave. Baltimore, MD 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause: Final disease or condition resulting in death

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus w/ complications  
peripheral vascular disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dendall R Faulkner

29c. License number

D 25643

29d. Date signed (Month, Day, Year)

02/01/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dendall R Faulkner MD 6565 N. Charles St Suite 209/Belt MD 21204

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.MILES, GORDON 2/1/08 6:00  
Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02977

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jean R. Moravec

2. Date of Death

January 29 2008

3. Time of Death

2:15 AM

4a. Facility Name (If not institution, give street and number)

Roland Park Place Nursing Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

090-36-7182

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

100 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
6-4-1907

9. Birthplace (State or Foreign Country)

Nebraska

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

830 W. 40th Street

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Central City Schools

17. Father's Name (First, Middle, Last)

Elmer Ross

18. Mother's Name (First, Middle, Maiden Surname)

Maude Scott

19a. Informant's Name/Relationship (Type, Print) (son)

Dr. Clayton L. Moravec, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1400 Lancaster Street Apt. 605 Baltimore, MD 21231

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

1/31/2008

20c. Location - City or Town, State

Catonsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc.  
3631 Falls Road Baltimore, Maryland 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End-stage dementia, unspecified

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
Years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

dense osteoporosis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D13657

29d. Date signed (Month, Day, Year)

January 29, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ISABELLE MACGREGOR, 700 W. 40th STREET, BALTIMORE, MD 21211

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02978

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hildegard K. Magrogan

2. Date of Death

February 2, 2008

3. Time of Death

12:55 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

212-20-5293

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 19, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8810 Walther Blvd. #1101

10f. Zip Code

21234

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

1 Year

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

School Bus Driver

16b. Kind of Business/Industry

Baltimore County

17. Father's Name (First, Middle, Last)

Carl Kraus

18. Mother's Name (First, Middle, Maiden Surname)

Theresa Maria Koch

19a. Informant's Name/Relationship (Type, Print)

Marian A. Currens (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4101 Slater Ave. Baltimore, Maryland 21236

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Ht. of Jesus Cem. 2/7/2008 Dundalk, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Provider

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIO-RESPIRATORY ARREST

Due to (or as a consequence of):

b. COPD

Due to (or as a consequence of):

c. OVARIAN CANCER METASTATIC

Due to (or as a consequence of):

20YRS

4WKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D19110

29d. Date signed (Month, Day, Year)

2/3/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL B. DILLON GBMC TOWSON, MD 21204

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

State Registrar

MAGROGAN, HILDEGARD  
Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02979

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Robert L. McKenzie

2. Date of Death

Month

Day

Year

3. Time of Death

01

30

2008

0830 AM

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE CITY

5. Social Security Number

220-82-2145

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

46

8. Date of Birth

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

June 18, 1961

9. Birthplace (State or Foreign  
Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1751 Burnham Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12 Years

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

George Lee McKenzie

18. Mother's Name (First, Middle, Maiden Surname)

Anna T. Klosterman

19a. Informant's Name/Relationship (Type, Print)

Georgiann Capsey (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1750 Burnham Road Dundalk, Maryland 21222

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) Entombment20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Holly Hill Mem. Gdns. 2/4/2008

Date

20c. Location - City or Town, State

Middle River, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Cardiomyopathy  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

1990

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Aortic Valve Replacement  
Due to (or as a consequence of):

1980-2006

c. Rheumatic Heart Disease  
Due to (or as a consequence of):

1980

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☒ Yes 2 ☐ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29b. Signature and title of certifier  
[Signature] MD  
29c. License number  
REF000  
29d. Date signed (Month, Day, Year)  
02/01/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Astor Singh, MD

Johns Hopkins Hospital

650 N Wolfe St Baltimore, MD

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02980

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Frank Mayeski, Jr.

2. Date of Death

January 31, 2008

3. Time of Death

12:30A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

614 Waterview Drive

4b. City, Town, or Location of Death

Curtis Bay

4c. County of Death

Anne Arundel Co.

5. Social Security Number

213-32-9136

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

8. Date of Birth (Month, Day, Year)

July 17, 1937

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Curtis Bay

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

614 Waterview Drive

10f. Zip Code

21226

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

Maryland Transportation Auth.

17. Father's Name (First, Middle, Last)

Frank Mayeski, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ukn.

19a. Informant's Name/Relationship (Type, Print)

Mrs. Theresa Mayeski (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

614 Waterview Drive Curtis Bay, Maryland 21226

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp. 2/5/2008

Date

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic lung cancer

Approximate Interval Between Onset and Death

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

E. Tso MD

29c. License number

D24170

29d. Date signed (Month, Day, Year)

January 31, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. Tso MD Richey Hospice 838 N. Eutaw St Baltimore MD 21201

31. Date filed (Month, Day, Year)

January 31, 2008

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, &lt;



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 02981

1- For State Registrar

Physician /Medical Examiner

Funeral Director

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JOHN T. MCCORMICK</b>   |  | 2. Date of Death<br>Month <b>02</b> Day <b>01</b> Year <b>08</b>  |  | 3. Time of Death<br><b>1337</b> M  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>204 Kuethe Road</b>   |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>  |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| 5. Social Security Number<br><b>214-18-2516</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>12-26-1922</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Glen Burnie</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |
| 10e. Street and Number<br><b>204 Kuethe Road</b>   |  | 10f. Zip Code<br><b>21060</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>                  |  | 16b. Kind of Business/Industry<br><b>Pantry Pride</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John NMN McCormick</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary E. Harman</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Jerry McCormick / son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>204 Kuethe Road; Glen Burnie, MD 21060</b>    |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glen Haven Mem. Park</b>   |  | 20c. Location - City or Town, State<br><b>MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Mark A. Vincent</b>  |  | 22. Name and Address of Facility<br><b>Singleton Funeral &amp; Cremation Services; 1 2nd Ave SW; Glen Burnie, MD 21061</b>                        |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Malignant Melanoma</b>   |  |   |  |  |  |
| 23b. Immediate Cause (Final disease or condition resulting in death)<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):   |  |   |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown   |  |   |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |   |  |  |  |
| 28a. Date of Injury (Month, Day Year)  |  |   |  |  |  |
| 28b. Time of Injury<br>M   |  |   |  |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |  |
| 28d. Describe how injury occurred  |  |   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Michael J. LaPenta</b>   |  |   |  |  |  |
| 29c. License number<br><b>D 21438</b>  |  |   |  |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>February 04, 2008</b>  |  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MICHAEL J. LAPENTA 441 DEFENSE HIGHWAY ANNAPOLIS MD 21401</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>  |  |   |  |  |  |
| 32. Registrar's Signature<br><b>[Signature]</b>  |  |   |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02982

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frank Novak

2. Date of Death  
Month Day Year

FEBRUARY 3, 2008

3. Time of Death

8:30 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

215-14-9131

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

02-04-1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

110 Royal Oak Dr. Unit H

10f. Zip Code

21015

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Credit Manager

16b. Kind of Business/Industry

Steel Company

17. Father's Name (First, Middle, Last)

Adam Novak

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Kelly

19a. Informant's Name/Relationship (Type, Print)

Richard Novak (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1330 Kings Lynn Ct Bel Air, MD 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Bel Air Memorial Gar.

Date

02-07-2008

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air  
Inc. 610 W. MacPhail Rd. Bel Air, MD 2101423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

b. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DDA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D0017695

29d. Date signed (Month, Day, Year)

February 3, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDALLAH J. HELOU, M.D.

7601 OSLER DRIVE TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
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any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

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within 24 hours after death.  
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completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02983

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond J. Noratel, Jr.

2. Date of Death  
Month Day Year  
February 4, 20083. Time of Death  
5:30 a. M

4a. Facility Name (If not institution, give street and number)

2823 Georgetown Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

218-44-0834

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

8. Date of Birth (Month, Day, Year)

April 15, 1946

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2823 Georgetown Road

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Monarch Trucking

17. Father's Name (First, Middle, Last)

Raymond J. Noratel, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Margaret W. McCabe

19a. Informant's Name/Relationship (Type, Print)

Lisa Bedell / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1572 Foxborough Drive Bel Air, Md. 21015

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp. 2/7/08

Date

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc. Towson, Md. 21204

1050 York Road

23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cirrhosis liver

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D50517

29d. Date signed (Month, Day, Year)

2/4/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gregory Levickos 1120 N. Rolling RD Balt MD 21228

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02984

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY

OTIS

2. Date of Death

02 Month 02 Day 2008 Year

3. Time of Death

5:00 A. M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

FOREST HILL HEALTH AND REHABILITATION

4b. City, Town, or Location of Death

FOREST HILL

4c. County of Death

HARFORD

5. Social Security Number

106-16-6850

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

8. Date of Birth (Month, Day, Year)

March 26, 1916

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

NY

10b. County

Suffolk

10c. City, Town or Location

Quogue

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

79 Old Depot Road

10f. Zip Code

11959

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

At Home

17. Father's Name (First, Middle, Last)

August Schmiemann

18. Mother's Name (First, Middle, Maiden Surname)

Mary Garrecht

19a. Informant's Name/Relationship (Type, Print)

Ed Beck-son in law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

322 Donald Circle-Forest Hill, Maryland 21050

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

EVANS FUNERAL CHAPEL AND CREMATION SERVICES BELAIR

Date

2-4-08

20c. Location - City or Town, State

Forest Hill, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

EVANS FUNERAL CHAPEL AND CREMATION SERVICES 3 Newport Drive Forest Hill, MD 21050

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *respiratory distress*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *possible aspiration*  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D32275

29d. Date signed (Month, Day, Year)

February 4, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. DAVID DUNN 615 MACPHAIL ROAD BEL AIR, MD 21014

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760, X

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02985

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LORRAINE B.

OAKES

2. Date of Death

FEB. 2, 2008

3. Time of Death

8:30 P M

4a. Facility Name (If not institution, give street and number)

CARROLL LUTHERAN VILLAGE

4b. City, Town, or Location of Death

WESTMINSTER

4c. County of Death

CARROLL

Funeral  
Director

5. Social Security Number

216-24-6583

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

3/26/1928

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

CARROLL

10c. City, Town or Location

WESTMINSTER

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

236 ST. MARK WAY

10f. Zip Code

21158

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

SALES PERSON

16b. Kind of Business/Industry

RETAIL

17. Father's Name (First, Middle, Last)

FRANK JOSEPH HUDSON

18. Mother's Name (First, Middle, Maiden Surname)

BERTHA ESTELLE STEINBACHER

19a. Informant's Name/Relationship (Type, Print)

WILLIAM LEROY OAKES -SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2689 DAY LILLY RUN, THE VILLAGES, FL 32162

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

ALL COUNTY CREMATION 2/4/08

20c. Location - City or Town, State

SYKESVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A.

254 E. MAIN ST., WESTMINSTER, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Failure to thrive

Due to (or as a consequence of):

b. Malnutrition

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

6 months

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W. Oakes MD

29c. License number

DS2035

29d. Date signed (Month, Day, Year)

Feb 4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BILLY CHACKO 29 Stoner Avenue

WESTMINSTER MD 21157

31. Date filed (Month, Day, Year)

FEB 05 2008

Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.


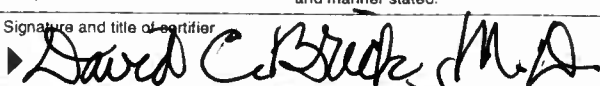
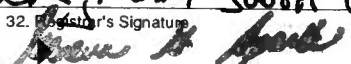
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2008 02986

1- For State Registrar

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Roger Florand Perron</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>1</b> Year <b>2008</b>  |  | 3. Time of Death<br><b>5:50 a M</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Harford Memorial Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Havre de Grace</b>  |  | 4c. County of Death<br><b>Harford</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>002-20-5858</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                                 | 8. Date of Birth<br>(Month, Day, Year)<br><b>MAR 3 1930</b>                                 | 9. Birthplace (State or Foreign Country)<br><b>New Hampshire</b>                               |
|   | Usual Residence of Decedent   |  |   |  |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Aberdeen</b>   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|   | 10e. Street and Number<br><b>410 Edmund Street</b>  |  |   |  | 10f. Zip Code<br><b>21001</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1951-71</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Technical Sergeant</b>   |  | 16b. Kind of Business/Industry<br><b>U. S. Airforce</b>                                     |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Joseph Perron</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eva Rose Daneau</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Louise Perron - wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>410 Edmund Street, Aberdeen, MD 21001</b>  |  |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>  |  | Date<br><b>2/4/2008</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>                                 |  |
|   | 21. Signature of Funeral Service Licensee<br><br><b>Steven H. Williams</b>   |  |   |  | 22. Name and Address of Facility<br><b>Cremation Society of Maryland, Inc.</b><br><b>299 Frederick Road, Baltimore, MD 21228</b>   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Acute large brainstem infarct</b><br>Due to (or as a consequence of):<br>b. <b>Severe anemia</b><br>Due to (or as a consequence of):<br>c. <b>Gastrointestinal bleeding</b><br>Due to (or as a consequence of):<br>d. <b>Vascular occlusive disease</b> |  |   |  |  |  |   |  |
|   | Approximate Interval Between Onset and Death<br><b>Days</b><br><b>Days</b><br><b>Days</b><br><b>Years</b>   |  |   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus</b><br><b>Hypertension</b>   |  |   |  |  |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|   | 27. Manner of death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br><br><b>David C. Brick, M.D.</b>   |   |  |   | 29c. License number<br><b>D0036940</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 1, 2008</b> |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID C. BRICK, M.D. SOUTH UNION AVENUE, HAVRE DE GRACE 2108</b>   |   |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>   |   |  |   | 32. Registrar's Signature<br> |  |  |   |  |

2-1-08 08:50  
Baltimore, Maryland 21215-0036  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached to use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached to use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02987

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ESTLE E. POWERS

2. Date of Death

Month 02 Day 03 Year 08

3. Time of Death

0341M

4a. Facility Name (If not institution, give street and number)

Riva Terrace Assisted Living

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

410-18-9622

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 18, 1917

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

715 211th Street

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Acetylene Burner

16b. Kind of Business/Industry

Koppers Company

17. Father's Name (First, Middle, Last)

George

18. Mother's Name (First, Middle, Maiden Surname)

Powers

Lillie

Gibson

19a. Informant's Name/Relationship (Type, Print)

Linda Bothe (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

218 Baybourne Drive Arnold, Maryland 21012

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Mem. Pk.

Date

02/06/08

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.A.

3204 Mountain Road Pasadena, Maryland 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE CHF

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 WKS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

ALF

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 21438

29d. Date signed (Month, Day, Year)

February 04, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL J. LAVENTA m 445 DEFENSE HIGHWAY ANNAPOLIS MD 21404

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

0008 02988

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner  |  | 1. Decedent's Name (First, Middle, Last)<br><b>Nicholas John Pappas</b>  |  |   |  | 2. Date of Death<br>Month <b>January</b> Day <b>29</b> Year <b>2008</b>                          |  | 3. Time of Death<br><b>12:50 P M</b>   |  |
| Funeral Director   |  | 4a. Facility Name (If not institution, give street and number)<br><b>Rockville Nursing Home</b>  |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |  |  |  |
| 5. Social Security Number<br><b>002-12-8098</b>  |  | 6. Sex<br><b>1 M 2 F</b>   |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>May 2, 1928</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>New Hampshire</b>   |  |
| Usual Residence of Decedent  |  |  |  |   |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Silver Spring</b>   |  |  |  | 10d. Inside City Limits<br><b>1 Yes 2 No</b>   |  |
| 10e. Street and Number<br><b>3310 North Leisure Blvd. #215</b>   |  |  |  | 10f. Zip Code<br><b>20906</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |  |
| 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b><br>If Yes, Give Year or Dates: <b>WWII/Korea</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No Specify:</b>          |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b>                          |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+) <b>4</b>  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Auditor</b>                         |  | 16b. Kind of Business/Industry<br><b>Federal Government</b>                                      |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Theophanes Pappas</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Sumame)<br><b>Soltana Not Available</b>  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Andrew G. Pappas/Nephew</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>55 South Spring Street, Concord, NH 03301</b>   |  |  |  |  |  |
| 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc.</b>  |  | Date<br><b>February 3, 2008</b>   |  | 20c. Location - City or Town, State<br><b>Bethesda, Maryland</b>                                 |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  | M01346   |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814</b> |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>End Stage Congestive Heart Failure</b><br>Due to (or as a consequence of):<br><b>Hypertension</b><br>Due to (or as a consequence of):<br><b>Chronic Renal Failure</b><br>Due to (or as a consequence of): |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>1 Month</b><br><br><b>Years</b><br><br><b>1 Month</b> |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 Yes 2 No 9 Unknown</b>   |  | 23c. If yes, outcome of pregnancy<br><b>1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)</b><br><b>9 Unknown</b> |  |   |  | 23d. Date of delivery<br>Month <b>February</b> Day <b>3</b> Year <b>2008</b>                     |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal Tumor of Uncertain Behavior</b><br><b>Gout</b>  |  |  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b> |  |  |  |
| 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>   |  |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>  |  | Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b>   |  | Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>  |  | 26. Place of Death (Check only one)  |  |  |  |
| 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><b>1 Yes 2 No</b>  |  | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>   |  | 29b. Signature and title of certifier<br><b>Shama R. Mittal MD</b>   |  | 29c. License number<br><b>DO061382</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>January 29, 2008</b>                                   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Shama Mittal, M.D. 14816 Physicians Lane, #152, Rockville, MD 20850</b>   |  |  |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>  |  | 32. Registrar's Signature<br>  |  |   |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #3, per MD, g876, 2/5/08 TT Certificate of Death

Reg. No. 2008 02989

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Roger Pryor

2. Date of Death  
Month Day Year

January 22, 2008

3. Time of Death

5:57 PM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center - Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

357-42-5056

6. Sex  
☒ M ☐ F

7. Age (In yrs. last birthday)  
Yrs. 60

8. Date of Birth  
(Month, Day, Year)

Mar. 23, 1947

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1408 Bonnett Place Unit K

10f. Zip Code

21015

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12 College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Soldier

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Theodore Randall Pryor

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Lucille Mabry

19a. Informant's Name/Relationship (Type, Print)

Deborah A. Pryor / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1408 Bonnett Place Unit K, Bel Air, MD 21015

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington Natl. Cem.

Date

3-11-08

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

Charles A. Engel

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Rd., Abingdon, MD 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

two weeks

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
☐ Yes ☒ No ☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Grade Four - Glioblastoma Multiforme

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?  
☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?  
☐ Yes ☒ No

25. Was case referred to medical examiner?  
☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Brien Silverman

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

January 22, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Doctor Brien Silverman, Johns Hopkins Bayview, 4940 Eastern Avenue, Baltimore, Maryland

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02990

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SONIA M. PRATT

2. Date of Death

January 31 2008

3. Time of Death

9:30 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

DOCTORS COMMUNITY HOSPITAL

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGES

5. Social Security Number

578-78-7800

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
07-23-1956

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

UPPER MARLBORO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

13406 MESSENGER PLACE

10f. Zip Code

20774

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

BUDGET ANALYSIS

16b. Kind of Business/Industry

DEPT. OF TREASURER

17. Father's Name (First, Middle, Last)

WALLACE

SPENCER

18. Mother's Name (First, Middle, Maiden Surname)

LUCILLE

HUTCHINS

19a. Informant's Name/Relationship (Type, Print)

THOMAS PRATT - HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13406 MESSENGER PL., UPPER MARLBORO, MD 20774

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

02-08-08

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

B.E. Taylor

22. Name and Address of Facility

RONALD TAYLOR, II FUNERAL HOME  
108 WEST NORTH AVENUE, BALTIMORE, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Respiratory Failure

b. Due to (or as a consequence of):

Anoxic Encephalopathy

c. Due to (or as a consequence of):

Sepsis

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Samuel F. Aspin, MD

29c. License number

MD060611

29d. Date signed (Month, Day, Year)

2/1/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Samuel F. Aspin, MD 8118 Good Luck Rd., Lanham, MD, 20707

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPRATT, SONIA MICHELL  
Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 17 per ch g76 2-5-08 vt

State of Maryland Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02991

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SEWERYN

PIASECKI

2. Date of Death  
Month Day Year  
JANUARY 31 20083. Time of Death  
7:25A MFuneral  
Director

4a. Facility Name (If not institution, give street and number)

ENGLISH GARDENS ASSISTED LIVING

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

312-42-2963

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

03/30/1911

9. Birthplace (State or Foreign Country)

POLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2600 GAGE COURT, APT. C

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ACCOUNTANT

16b. Kind of Business/Industry

ACCOUNTING

17. Father's Name (First, Middle, Last)

HERCHEL ~~HERSHEL~~

PIASECKI

18. Mother's Name (First, Middle, Maiden Surname)

ESTHER

WEINTRAUB

19a. Informant's Name/Relationship (Type, Print)

PATRICE PRICE / NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2172 STOWMONT COURT, DUBLIN, OH 43106

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

TIFERETH ISRAEL CONG. 02/03/2008 BALTIMORE, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*Michael Burger*

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.  
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Pulmonary arrest*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*immediate*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Pneumonia*  
Due to (or as a consequence of):*3 weeks*c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) ASSISTED LIVING

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Julian Jankovits MD*

29c. License number

D25039

29d. Date signed (Month, Day, Year)

01/31/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JULIAN JANKOVITS MD 2835 Smith Ave, BALT. MD 21209

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

*Donna L. Smith*State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02992

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ELLEN CECELIA QUINN

2. Date of Death

February 2, 2008

3. Time of Death

6:48 A.M.

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

220-46-3153

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

101

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth (Month, Day, Year)

Mar. 10, 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2300 Dulaney Valley Road

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10 years

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Receptionist

16b. Kind of Business/Industry

Apartments

17. Father's Name (First, Middle, Last)

Patrick Joseph Quinn

18. Mother's Name (First, Middle, Maiden Surname)

Mary Teresa Kerr

19a. Informant's Name/Relationship (Type. Print)

Elizabeth Yancey (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

29 Glen Alpine Road Phoenix, Maryland 21131

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cemetery 2-7-08

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

*George Fennane*

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.  
6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

*Chronic Lung Disease*

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Pneumonia & Arthritis*  
*Arteriosclerosis*

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D 15509

29d. Date signed (Month, Day, Year)

2.4.08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDDIE NAKHODA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

*[Signature]*

State Registrar

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

6:48 A.M.

FEBRUARY 2, 2008

ELLEN QUINN

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02993

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Geroldine Roth

2. Date of Death

Month 2 Day 2 Year 2008

3. Time of Death

6:55p<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Charlestown Care Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

220-01-5810

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

8. Date of Birth

If Under 1 Year If Under 24 Hrs.  
Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

FEB 28 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

701 Maiden Choice Lane

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Public Education

17. Father's Name (First, Middle, Last)

Frederick Tribull

18. Mother's Name (First, Middle, Maiden Surname)

Emma Powell

19a. Informant's Name/Relationship (Type, Print)

H. Mark Roth - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6240 Copper Sky Court, Columbia, MD 21045

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

2/4/2008

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Steven H. Williams

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Road, Baltimore, MD

21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End-stage Dementia  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

cerebral vascular accident

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Steven H. Williams, MD

29c. License number

D-4377

29d. Date signed (Month, Day, Year)

2/3/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deneen Bowlin, MD 701 Maiden Choice Lane, Catonsville, MD 21228

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

Steven H. Williams

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, 10

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2008 02994

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elsie M. Razgaitis

2. Date of Death

February 4 2008

3. Time of Death

6:45 a<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

314 Whitaker Mill Road

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

5. Social Security Number

211-12-6966

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAR 10 1922

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Fallston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

314 Whitaker Mill Road

10f. Zip Code

21047

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

10

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Assembler

16b. Kind of Business/Industry

Western Electric

17. Father's Name (First, Middle, Last)

Blair Burkhart

18. Mother's Name (First, Middle, Maiden Surname)

Mary Baker

19a. Informant's Name/Relationship (Type, Print)

Alfred Razgaitis - husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

314 Whitaker Mill Road, Fallston, MD 21047

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc. 2/5/2008

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Steven H. Williams

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Road, Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Cardiomyopathy

b. Due to (or as a consequence of):

Severe Mitral regurgitation

c. Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

6 mos

5 yrs

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Tricuspid regurgitation

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be  
3 ☐ Suicide 6 ☐ determined  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Attending

29c. License number

D16444

29d. Date signed (Month, Day, Year)

February 4th 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Vijay Nair, 602 S. Atwood Road, Bel Air, MD 21014

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02995

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Schlorek Rahikka

2. Date of Death

January 31, 2008

3. Time of Death

1227 M

4a. Facility Name (If not institution, give street and number)

St. Agnes Health Care

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

132-05-6595

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 22, 1917

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

709 Maiden Choice Lane, RGT 302

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Mathematician/Statistician

16b. Kind of Business/Industry

Television/Advertising

17. Father's Name (First, Middle, Last)

Samson Adam Schlorek

18. Mother's Name (First, Middle, Maiden Surname)

Helen Alexandria Zuk

19a. Informant's Name/Relationship (Type. Print)

Robert Rahikka, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11869 New Country Lane Columbia, MD 21044

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc. 02/01/08

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Thomas Gregor

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Road Baltimore, Maryland 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Three Days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Decomposing

Atrial Fibrillation

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

BC9916795

29d. Date signed (Month, Day, Year)

January 31, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Meghan Checkley 900 South Caton Avenue Baltimore, Maryland

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

John H. Smith

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Rahikka Mary S. Division of Vital Records, P.O. Box 68760, F

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2008 02296

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lloyd Reed

2. Date of Death

Month Day Year  
02 01 2008

3. Time of Death

10:05 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

215-44-1521

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

62

8. Date of Birth (Month, Day, Year)

10 30 45

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4705 Moravia Run Way

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Postal Carrier

16b. Kind of Business/Industry

Post Office

17. Father's Name (First, Middle, Last)

Wayne Reed

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Lee

19a. Informant's Name/Relationship (Type, Print)

Sherry Reed-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4705 Moravia Run Way Baltimore, MD 21206

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest

Date

2/8/08

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

Synette K. Jones

22. Name and Address of Facility

March F/H East  
1101 E. North Ave Baltimore, MD 21202

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End-stage Pancreatic Cancer  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☐ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)  
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

liver metastasis, Diabetes, Hypertension  
hip and knee replacement surgeries

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

02-01-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amir KAZORY, Good Samaritan Hospital, Baltimore MD 21239

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2008 02998

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Carla Flo Ridgley</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>1</b> Year <b>2008</b>  |  | 3. Time of Death<br><b>8:20 PM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>1905 Madison Road</b>  |  | 4b. City, Town, or Location of Death<br><b>Dundalk</b>   |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| 5. Social Security Number<br><b>216-52-4209</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>February 5, 1950</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Harford</b>  |  | 10c. City, Town or Location<br><b>Belcamp</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>1231 Brice Square</b>   |  | 10f. Zip Code<br><b>21017</b>  |  |
| 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 years</b><br>College (1-4or 5+) <b>Terminal Manager</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Terminal Manager</b>   |  | 16b. Kind of Business/Industry<br><b>Rite-Aid Corp</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Wilbur Southerly</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Ours</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Corina &amp; Charles Ridgley / Daughter son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1231 Brice Square, Belcamp, Maryland 21017</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holly Hill Memorial</b>   |  | 20c. Location - City or Town, State<br><b>Middle River, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Anthony Connelly</b>  |  | 22. Name and Address of Facility<br><b>Connelly Funeral Home Of Dundalk, P.A.<br/>7110 Sollers Point Road, Dundalk, Md. 21222</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Breast Cancer</b><br>Due to (or as a consequence of):<br>a. <b>Breast Cancer</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><b>3 1/2 years</b>   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death<br><input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Other (specify)  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Sisters Home</b> |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>[Signature]</b>  |  |
| 29c. License number<br><b>028489</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/4/08</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ficta H Sokal no 206 Hays St Bel Air Md 21014</b>   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOANN BRIGHT RICAS

2. Date of Death

FEB 01 2008

3. Time of Death

12:54 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

None

5. Social Security Number

215-32-7471

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

8. Date of Birth (Month, Day, Year)

May 15, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1402 Shefford Road

10f. Zip Code

21239

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Joseph McSorley Bright

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Stover

19a. Informant's Name/Relationship (Type, Print)

Timothy Arthur Ricas

Hus.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1402 Shefford Road Baltimore, Maryland 21239

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GreenMount Crematory

Date

2/4/08

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Annis Stephen Kenakis

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home Inc  
6500 York Road Baltimore, Maryland 21212

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE  
Due to (or as a consequence of):b. SEPSIS  
Due to (or as a consequence of):c. ANOXIC BRAIN INJURY  
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

EMPHYSEMA, HYPOTHYROIDISM,  
HYPERTENSION

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

02/01/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APOORVBROER, GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BLVD, BALTIMORE, MD

31. Date filed (Month, Day, Year)

FEB 05 2008

32. Registrar's Signature

[Signature]

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

JOANN BRIGHT RICAS

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, &lt;

10

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 03000

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |  |   |  |
|---|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Ralph Robertson, Sr</b>   |  |  |  | 2. Date of Death<br>Month <b>02</b> Day <b>03</b> Year <b>2008</b>   |  | 3. Time of Death<br><b>5:05 A M</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Maryland Masonic Homes</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Cockeysville</b>  |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>233-24-6670</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 21, 1919</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>WV</b>   |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Cockeysville</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 11. Street and Number<br><b>300 Interenational Cir.</b>  |  | 10f. Zip Code<br><b>21030</b>   |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>N/A</b>            |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Entrepreneur</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Service Station</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Hubert Robertson</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margie Baker</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert R. Robertson, Jr.</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4766 Wellesly Dr. Woodbridge, VA 22192</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Memorial Gardens</b>   |  | 20c. Location - City or Town, State<br><b>Timonium, MD</b>  |  |
|   | 21. Signatory of Funeral Service License<br><b>Bryan W. Clary</b>   |  |  |  | 22. Name and Address of Facility<br><b>Lemmon Funeral Home of Dulaney Valley, Inc.<br/>10 W. Padonia Road Timonium, MD 21093</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acute Cerebrovascular Accident</b>  |  |  |  | Approximate Interval Between Onset and Death<br><b>Weeks</b>   |  |   |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b>  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  |  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify):<br><input type="checkbox"/> Unknown |  |   |  |
|   | 23d. Date of delivery<br>Month Day Year   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Arrhythmia, HIOCHF, HIO hemodynamic CVA<br/>HIO CAD, Depression, Dementia</b>  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify): |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  |  |  | 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  | 29b. Signature and title of certifier<br><b>R.T. Liberto, M.D.</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>D21464</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>2-3-08</b>   |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert Liberto, M.D. 300 International Circle Cockeysville, Md 21030</b>   |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br><b>FEB 05 2008</b>   |  |  |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |   |  |
|   |   |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0036

p. mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.